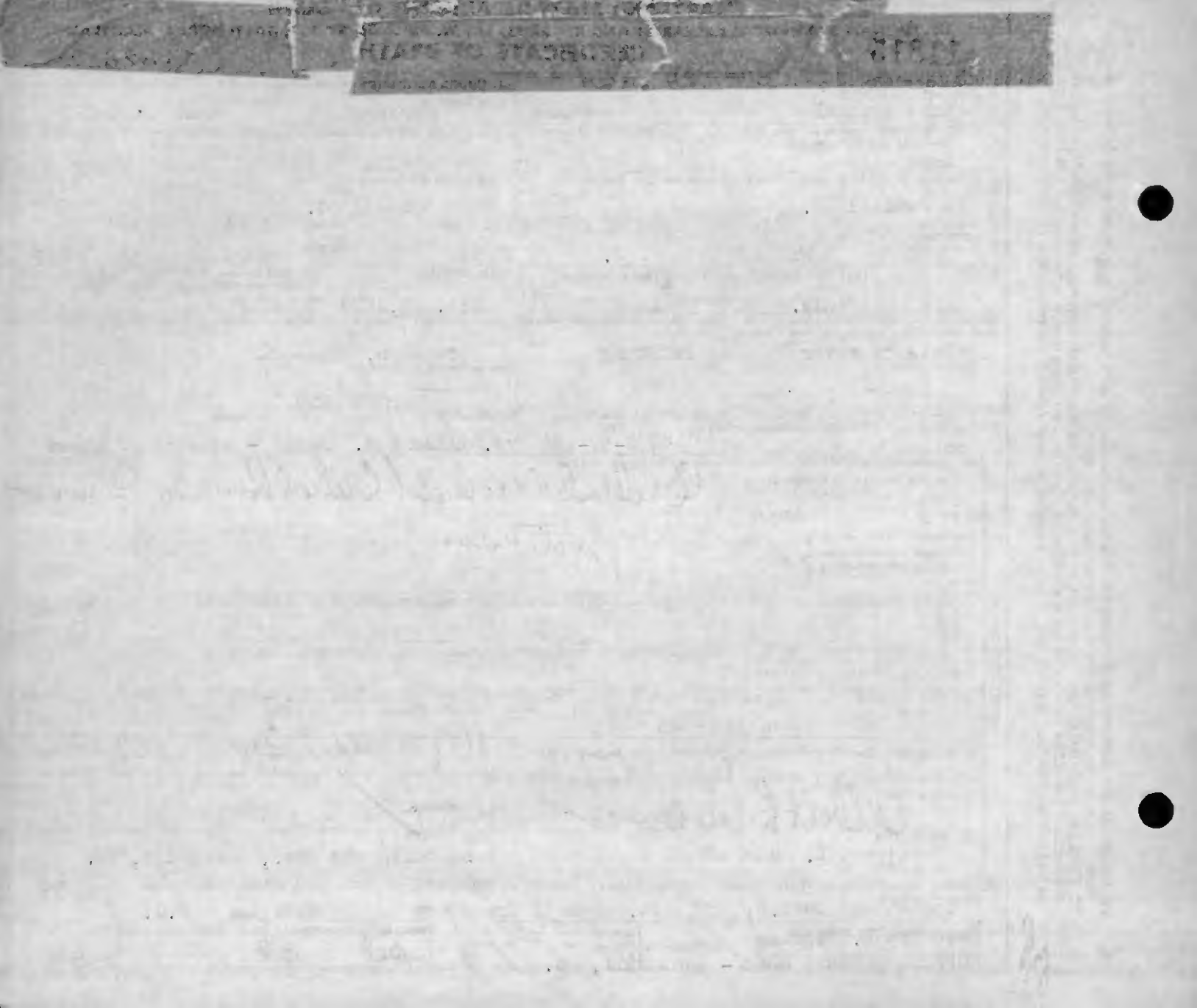


DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11815 CERTIFICATE OF DEATH 11828

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 24 Randall St.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 24 Randall St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM		Middle J.		Last ANDRIE		4. DATE OF DEATH Month SEPT		Day 5		Year 1967		5. SEX male		6. COLOR OR RACE cauc.			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 29, 1879		9. AGE (In years last birthday) 87 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Photo Engraver		10b. KIND OF BUSINESS OR INDUSTRY Printing		11. BIRTHPLACE (County & State, or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME UNKNOWN			
14. MOTHER'S MAIDEN NAME UNKNOWN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 0780-59-116		17. INFORMANT Mrs. Millicent B. Andrie - same as #2 above		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Aneurysm (Cerebral Hemorrhage) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Immediate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 111		(County) 46		(State) 9/5		21. I certify that (I) (this hospital) attended the deceased from 11/1 , 19 66 to 9/5 , 19 67 that (I) (we) last saw the deceased alive on 11/1 , 19 67 and that death occurred at 11/1 from the causes and on the date stated above.		22a. SIGNATURE Albert L. Anderson		22b. DATE SIGNED 11/1	
22c. PHYSICIAN'S NAME (Type) Albert L. Anderson, MD		22d. ADDRESS 44 Southgate Ave., Annapolis, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Sept. 6, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Crematory		23d. LOCATION (City, town or county) Washington D.C.		23e. REC'D BY REGISTRAR SEP 7 1967		23f. REGISTRAR'S SIGNATURE Charles Judge			
24. FUNERAL DIRECTOR'S SIGNATURE Deverley E. Hopping		24a. ADDRESS HOPPING FUNERAL HOME - Annapolis, Md.															



11816

CERTIFICATE OF DEATH

11829

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>H.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>Box 392 B Rt#4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>R.</u> Last <u>Baker</u>				4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>19 67</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/20/98</u>	
9. AGE (In years lost birthday) <u>69</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Henry Baker</u>				14. MOTHER'S MAIDEN NAME <u>Martha Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-07-8654</u>		17. INFORMANT Address <u>Hospital Records, Crownsville, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism; uremia</u> DUE TO (b) <u>Arteriosclerotic Hypertensive cardio-vascular disease.</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> , 19 <u>66</u> , to <u>9/14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/14</u> , 19 <u>67</u> , and that death occurred at <u>7:00</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>C. Dorkan</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>9/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. Dorkan</u>				22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9-17-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John</u>		23d. LOCATION (City or town) (County) (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR <u>Marshall R. Hayes 638 N. Gilmour St Baltimore</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11812

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11817

CERTIFICATE OF DEATH

11830

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 9. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEO G. MEADE, MARYLAND		c. LENGTH OF STAY IN 1b 3 hrs 10 Min	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH AH FT GEO G MEADE, MARYLAND		d. STREET ADDRESS 3 HILLCREST DRIVE	
3. NAME OF DECEASED (Type or print) BEALL, INF MALE First Middle Last		4. DATE OF DEATH Month SEPTEMBER Day 3 Year 67	
5. SEX MALE	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 SEPT 67 9. AGE (In years last birthday) yrs. 3 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (County & State, or foreign country) ANNE ARUNDEL, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH D. BEALL		14. MOTHER'S MAIDEN NAME JEAN ANDERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JOSEPH BEALL(F) LAUREL, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: PREMATURITY (575 GRAMS) IMMEDIATE CAUSE (a) 7625 DUE TO PRIMARY ATELECTASIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if) (this hospital) attended the deceased from 3 Sept 1967 to 3 Sept 67 , 19__, that (if) (we) last saw the deceased alive on 3 Sept 1967 , and that death occurred at 3:30P M, from causes and on the date stated above.			
22a. SIGNATURE <i>Robert F. Cullen</i>		22b. DATE SIGNED 3 Sept 67	
22c. PHYSICIAN'S NAME (Type) ROBERT F. CULLEN, CPT, MCC		22d. ADDRESS KIMBROUGH AH, FORT GEO G. MEADE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/6/67	23c. NAME OF CEMETERY OR CREMATORY St Marys Cem	23d. LOCATION (City or Town) (County) (State) Laurel P. G. Md.
24. FUNERAL DIRECTOR De Witt Donaldson <i>W. Harrison</i>		25a. REC'D BY REGISTRAR DATE SEP 11 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

11311

UNITED STATES DEPARTMENT OF AGRICULTURE

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

TO THE HONORABLE MEMBERS OF THE HOUSE OF REPRESENTATIVES

AND TO THE SENATORS FROM THE STATE OF NEW YORK

AND TO THE MEMBERS OF THE LEGISLATURE

OF THE STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11813 CERTIFICATE OF DEATH 11831											
1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> c. LENGTH OF STAY IN <u>1 Month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>40 Woodward Drive</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>Dade</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Miami</u> <u>483</u> d. STREET ADDRESS <u>3301 NE 5 Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ELLA WHITTEL BEARDSLEY</u>				4. DATE OF DEATH Month <u>9</u> - Day <u>10</u> Year <u>1967</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/16/90</u>		9. AGE (in years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <u>House mother</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>College</u>		11. BIRTHPLACE (County & State, or foreign country) <u>VIENNA, Illinois</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LINDORF O. WHITTEL</u>				14. MOTHER'S MAIDEN NAME <u>Amanda F. Farnsworth</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>24 4 515</u>		17. INFORMANT <u>Melville W. Beardsley - Above</u> Address <u>1 A. B. D</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>4231</u> DUE TO <u>Arteriosclerotic Cardiovascular disease</u> (b) <u>few minutes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u> </u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u> </u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>											
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m. 9:05</u> <u>9/10/67</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>son's home</u>		20f. (City or town) <u>Severna Park</u> (County) <u>A.A.</u> (State) <u>Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1962</u> to <u>Sept 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 19 67</u> , and that death occurred at <u>4:05 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Ray M. Smith</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> DATE <u>9/10/67</u> SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>RAY M. SMITH</u> 22d. ADDRESS <u>Severna Park Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>Sept 14, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Washington</u>		23d. LOCATION (City, town or county) <u>Kansas City</u> (State) <u>Missouri</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Barranco</u> ADDRESS <u>Severna Park, Md.</u>											
25a. REC'D BY REGISTRAR <u>SEP 14 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

County of _____

City of _____

County of _____

City of _____

County of _____

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County of _____

City of _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

Items-12&21 Film 392 9-13-67 ams		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #1d Film #0392 9/13/67 ph		11833	
11819 MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hosp.</u>		e. STREET ADDRESS <u>137 Georgetown Rd</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James E. Bendall Jr.</u>		4. DATE OF DEATH <u>9/1/67</u>		5. SEX <u>Male</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/12/1926</u>	
9. AGE (In years lost birthday) <u>41</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>court reporter</u>		11. BIRTHPLACE (State or foreign country) <u>Roanoke, Va.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>James E. Bendall, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Metta Pattisall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mother - 137 Georgetown Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>871.0</u> DUE TO (b) <u>Overdose of drug (Barbiturates)</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Overdose of drug</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. - p.m. <u>19</u>		20d. INJURY OCCURRED - While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>home</u>	
20f. (City or town) <u>Annapolis</u>		(County) <u>Md.</u>		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>					
ACTUAL SIGNATURE <u>Albert L. Anderson</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>9/1/67</u>	
EXAMINER'S NAME (Type) <u>ALBERT L. ANDERSON</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county) <u>Annapolis, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 4, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenhill Cemetery</u>	
23d. LOCATION (City or Town) <u>Darville</u>		(County) <u>Pittsylvania</u>		(State) <u>Va.</u>	
24. FUNERAL DIRECTOR <u>Beverly E. Hopping</u>		25a. REC'D BY REGISTRAR <u>SEP 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
Hopping Funeral Home - Annapolis, Md.					

1901

March 24

1901

March 24

March 24

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March 24

11820

CERTIFICATE OF DEATH

11834

1 PLACE OF DEATH a COUNTY Anne Arundel b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c LENGTH OF STAY IN 1b Annopolis		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE Maryland b COUNTY Anne Arundel c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d STREET ADDRESS 137 Georgetown Rd. e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) Metta Pattisall BENDALL		4 DATE OF DEATH Month September Day 24 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH May 23, 1900
9 AGE (in years last birthday) 67 yrs		10 IF UNDER 1 YEAR Months 6 Days 19 Hours 67 Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Secretary		10b KIND OF BUSINESS OR INDUSTRY US Gov't.	
11 BIRTHPLACE (County & State, or foreign country) Hope Hill, N.C.		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME Henry Clegg Pattisall		14 MOTHER'S MAIDEN NAME Martha M. Odell	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16 SOCIAL SECURITY NO. 162-16-4339	
17 INFORMANT Mrs. Verna P. Binbee, Newland, N.C.		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO (b) SOIX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) immediate		INTERVAL BETWEEN ONSET AND DEATH immediate	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from Feb , 19 67 to 9/24 , 19 67 , that (I) (we) last saw the deceased alive on 9/24 , 19 67 , and that death occurred at 11:30 M, from causes and on the date stated above.			
22a SIGNATURE Richard I. Hochman, M.D.		22b DATE SIGNED 9/24/67	
22c PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d ADDRESS 16 McCreary Ave, Annapolis, Md.	
23a BURIAL (CREMATION, REMOVAL) (Specify) Burial	23b DATE THEREOF Sept. 27, 1967	23c NAME OF CEMETERY OR CREMATORY Greenhill Cemetery	23d LOCATION (City or Town) (County) (State) Danville, Pittsylvania, Va.
24 FUNERAL DIRECTOR Henry E. Hopping		25a REC'D BY REGISTRAR DATE SEP 26 1967	
25b REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11821

CERTIFICATE OF DEATH

11835

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Annapolis Cape St. Claire	
c. LENGTH OF STAY IN TB 1 day		d. STREET ADDRESS Box 27, Route 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) William H BLOCKINGER		4 DATE OF DEATH September 23, 1967	
5 SEX Male	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH December 4, 1906	9 AGE (In years most birthday) 60 yrs
8 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Inspector of Bldgs A.A. County		10b. KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (County & State, or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Wm. H. Blockinger Jr.		14 MOTHER'S MAIDEN NAME Unknown	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 213104576	
17 INFORMANT Mrs. Goldie Blockinger - Grove		Address	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO (b) Coronary Heart Disease DUE TO (c) with Anginal Syndrome 1 yr.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) this hospital attended the deceased from 6-1-67 to 9-23-67 that (I) we saw the deceased alive on 9-23-67 and that death occurred at 8:34 PM from causes and on the date stated above.			
22a. SIGNATURE Frank M. Shipley		22b. DATE SIGNED 9-25-67	
22c. PHYSICIAN'S NAME (Type) F.M. SHIPLEY		22d. ADDRESS Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9/27/67	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cem.	23d. LOCATION (City or town) (County) (State) Annapolis AA Md.
24. FUNERAL DIRECTOR Robert S. Barranco		25a. REC'D BY REGISTRAR SEP 27 1967	
ADDRESS Severna Park Md.		25b. REGISTRAR'S SIGNATURE Charles J. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11822

11836

1 PLACE OF DEATH a COUNTY Anne Arundel b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c LENGTH OF STAY IN 1b Annopolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE Maryland b COUNTY Anne Arundel c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d STREET ADDRESS 420 Hammond Place e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) Jennie Shearman BOWERS First Middle Last		4 DATE OF DEATH September 26 19 67 Month Day Year					
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH November 8, 1888	9 AGE (In years last birthday) 78 yrs	10 IF UNDER 1 YEAR Months Days Hours Min	11 IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME FREDERICK BOWERS		14 MOTHER'S MAIDEN NAME ELVINA MANCHESTER		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16 SOCIAL SECURITY NO. DOUGLAS BOWERS #2
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) left hemiparesis DUE TO (b) Cerebral embolism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Acute myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 96 hrs. 96 hrs. 2 wks.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MED. CAL. EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from June , 19 63 , to Sept. , 19 67 , that (I) (we) lost saw the deceased alive on 9/25 , 19 67 , and that death occurred on 12:20 P.M. from causes on and the date stated above.							
22a SIGNATURE John H. Hederman		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b DATE SIGNED 9/26/67			
22c PHYSICIAN'S NAME (Type) JOHN HEDERMAN		22d ADDRESS FOREST DR. ANNAPOLIS, MD.					
23a BURIAL, CREMATION, REMOVAL (Type) BURIAL	23b DATE THEREOF 11-2-67	23c NAME OF CEMETERY OR CREMATORY oak GROVE		23d LOCAL (City or town) (County) (State) FALL RIVER MASS			
24 FUNERAL DIRECTOR John M. Lybrowsky		ADDRESS Annapolis, Md.		25a REC'D BY REGISTRAR OCT 2 1967	25b REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11823

CERTIFICATE OF DEATH

11837

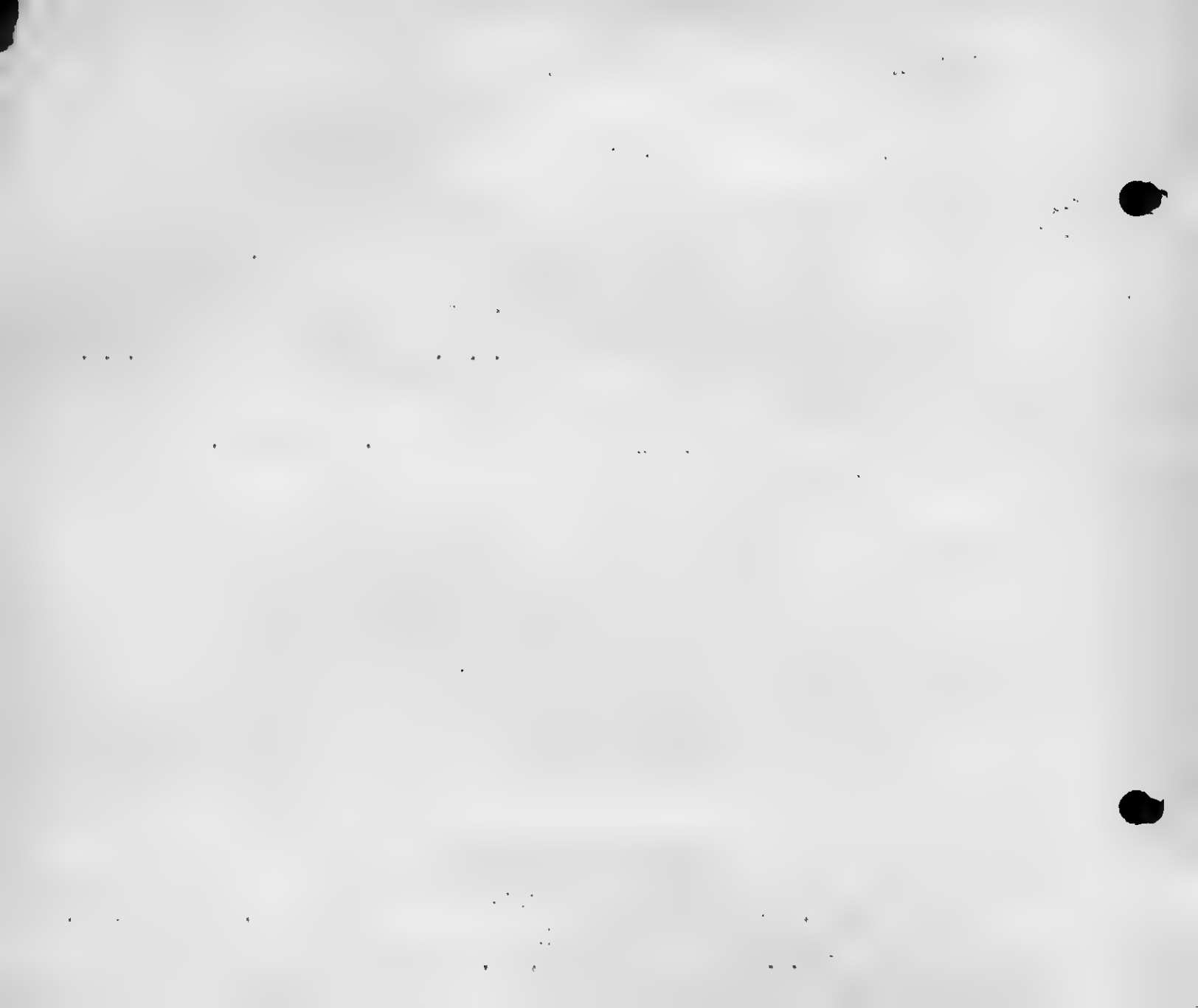
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb Severn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS Old Oak Rd.	
3. NAME OF DECEASED (Type or print) William Earl Boyd		4. DATE OF DEATH Month September Day 12 Year 19 67	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9 April 1904
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Athol Boyd		14. MOTHER'S MAIDEN NAME Lucy A. Franko	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1920 - 1945		16. SOCIAL SECURITY NO 21144	
17. INFORMANT Jane M. Boyd, Old Oak Road, Severn, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary embolization DUE TO (b) Acute myocardial infarction DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 days 10 + years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uretero-lithiasis R		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8 Sept. , 19 67 , to 12 Sept. , 19 67 , that (I) (we) last saw the deceased alive on 12 Sept. , 19 67 , and that death occurred at 2200 P , from causes and on the date stated above			
22a. SIGNATURE Michael F. Fornes MD		22b. DATE SIGNED 13 Sept 67	
22c. PHYSICIAN'S NAME (Type) MICHAEL F. FORNES LCDR MC, USN		22d. ADDRESS Naval Hospital, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 18 Sept. 67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or town) (County) (State) Ft. Myer, Virginia
24. FUNERAL DIRECTOR Kirkley Funeral Home, 421 Crane Highway, Glen Burnie, Md.		25a. REC'D BY REGISTRAR SEP 14 1967	



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
11824 11838															
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN life life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Prime Rose & Tyler Ave				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS Prime Rose & Tyler Ave • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) MATTHEWS MM BROWN				4. DATE OF DEATH Sept. 14 Month Sept. Day 14 Year 1967				5. SEX male 6. COLOR OR RACE negro 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Mar. 24-1899 WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 68 yrs. 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Caretaker				10b. KIND OF BUSINESS OR INDUSTRY *****				11. BIRTHPLACE (County & State, or foreign country) A.A.Co. Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles Brown				14. MOTHER'S MAIDEN NAME Katherine Hall											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-32-3756				17. INFORMANT Albert Brown - Rt. 3 Arnold Md. Box 13 Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Myocardial infarction (b) Myocardial infarction (c) Myocardial infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 1 day															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)															
21. I certify that (I) (this hospital) attended the deceased from 6-18-62 , to 9-14-67 , that (I) (we) last saw the deceased alive on 9-11-67 , and that death occurred at 9-14-67 , from the causes and on the date stated above.															
22a. SIGNATURE [Signature] 22b. DATE SIGNED 9-15-67															
22c. PHYSICIAN'S NAME (Type) A. T. ALLEN 22d. ADDRESS 62 CATHEDRAL ST															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Sept. 18-67 23c. NAME OF CEMETERY OR CREMATORY Pine Lawn 23d. LOCATION (City, town or county) (State) Bestgate Rd. Annapolis, Md.															
24. FUNERAL DIRECTOR'S SIGNATURE [Signature] ADDRESS C.E. Hicks 111 Annapolis, Md. 25a. REC'D BY REGISTRAR SEP 22 1967 25b. REGISTRAR'S SIGNATURE [Signature]															



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

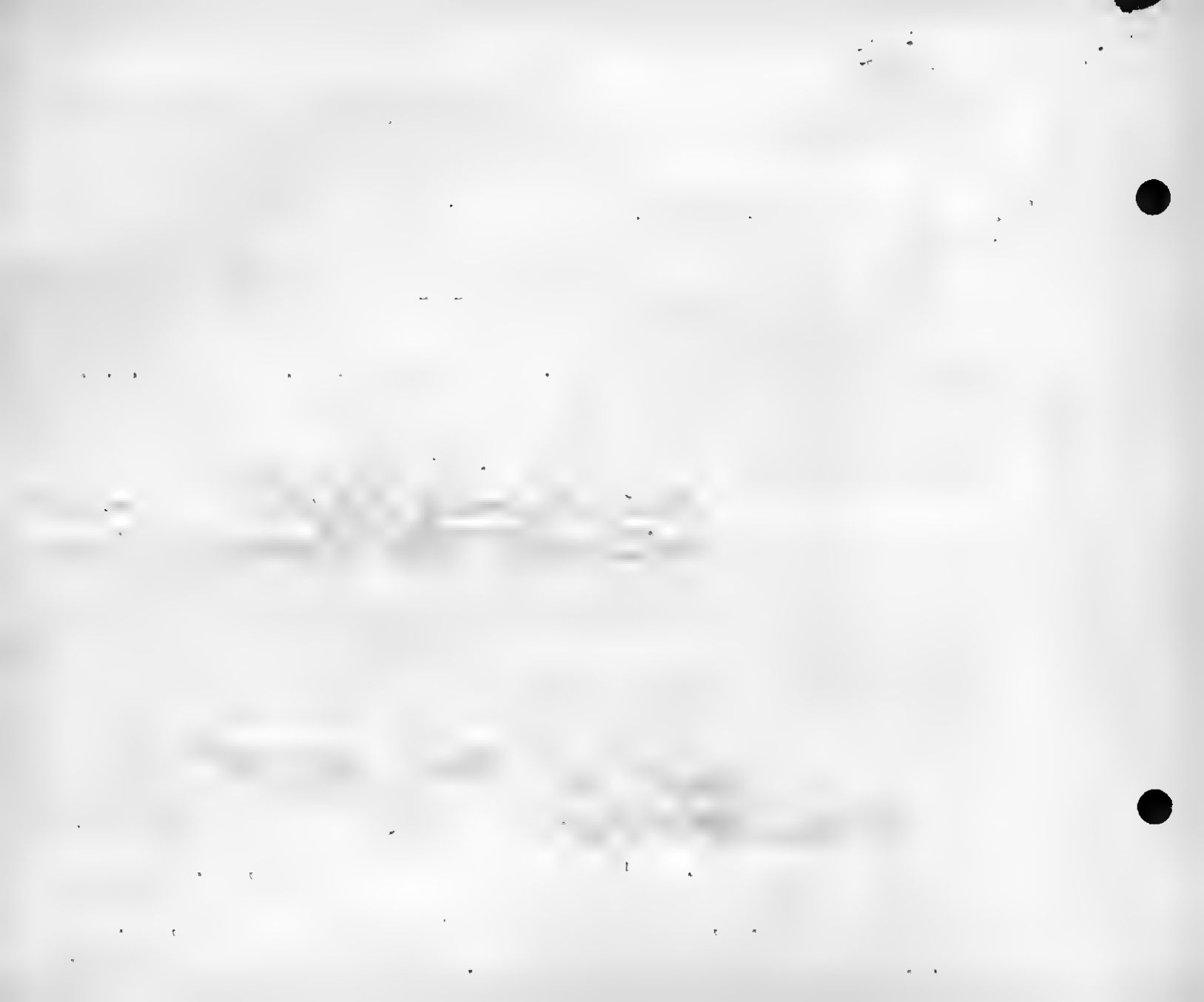
11825

11839

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) a. STATE MD. b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write C.D. and give nearest town) GLEN BURNIE		c. LENGTH OF STAY IN 1b GLEN BURNIE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 405 BLOSSOM LANE	
3. NAME OF DECEASED (Type or print) ROBERT E. BURKE		4. DATE OF DEATH Sept 15 1967	
5. SEX MALE	6. COLOR OF SKIN WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-01
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Joe & Fixture Builder		10b. KIND OF BUSINESS OR INDUSTRY Martin Co.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Burke		14. MOTHER'S MAIDEN NAME Mary Arnold	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO 222/05/3457	
17. INFORMANT Mrs. Mary Burke (wife)		Address Same as # 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO (b) Coronary Artery Disease DUE TO (c) Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH months > 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1966 to Sept 1967 , that (I) (we) last saw the deceased alive on Sept 1967 , and that death occurred on Sept 1967 , from causes and on the date stated above.			
22a. SIGNATURE Hilary T. O'Sherlihy M.D.		22b. DATE SIGNED 9-16-67	
22c. PHYSICIAN'S NAME (Type) Hilary T. O'Sherlihy		22d. ADDRESS Glen Burnie, Md. 21061	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 19, 67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem'l Park	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Md.
24. FUNERAL DIRECTOR R.V. Singleton		25a. REC'D BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11826

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11840

1 PLACE OF DEATH a. COUNTY <u>AACO</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admittance) a. STATE <u>MD</u> b. COUNTY <u>AACO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Glen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DON-NORTH ARUNDEL HOSP</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>JAMES A. CABELL</u>		4 DATE OF DEATH Month <u>9</u> Day <u>19</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-8-65</u>
9 AGE (In years last birthday) <u>2</u> yrs		10 FINDER 1 Year <u>19</u> Days <u>19</u> Hours <u>6</u> Min	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		12 KIND OF BUSINESS OR INDUSTRY <u>-</u>	
13 BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		14 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15 FATHER'S NAME <u>James N. Cabell</u>		16 MOTHER'S MAIDEN NAME <u>Carol Crook</u>	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or Unknown) <u>No</u>		18 SOCIAL SECURITY NO <u>None</u>	
19 INFORMANT <u>Mr. James N. Cabell (father)</u>		Address <u>Same as #2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: <u>10</u> IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>-</u> DUE TO (c) <u>-</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>2nd swimming pool</u>	
20c TIME OF DEATH Month Day Year Hour a.m. <u>9</u> p.m. <u>19</u> 1967		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e PLACE OF INJURY (Home form factory, street, office bldg, etc) <u>Home</u>	
20f (City or town) <u>1967</u>		20g (County) <u>MD</u>	
20h (State) <u>MD</u>		21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>	
22 ACTUAL SIGNATURE <u>E. Linhardt</u>		22. DATE SIGNED <u>9-19-67</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		23a CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town or county) <u>Glen Burnie, Maryland</u>		23b ADDRESS (Street, city, town or county) <u>Alum Creek, W. Virginia</u>	
23c BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		23d DATE THEREOF <u>Sept. 23, 1967</u>	
23e NAME OF CEMETERY OR CREMATORY <u>Fork of Coal Cem.</u>		23f LOCATION (City or town) (County) (State) <u>Alum Creek, W. Virginia</u>	
24 FUNERAL DIRECTOR <u>R. V. Singleton</u>		25a RECD BY REGISTRAR DATE <u>SEP 21 1967</u>	
25b REGISTRAR'S SIGNATURE <u>Charles J. J...</u>		25c REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

11841

11827

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Linthicum		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Linthicum on Pennsylvania RR tracks		d. STREET ADDRESS 1706 St. Paul St.	
3 NAME OF DECEASED (Type or print) FRANCES LORETTA CAMPBELL		4. DATE OF DEATH Month September Day 9 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May-30-23
9. AGE (In years last birthday) 44 yrs		10. FUND 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Clarkston, Ga.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Curtis S. Porter		14. MOTHER'S MAIDEN NAME Naomi L. Grisk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 265-346888	
17. INFORMANT Naomi Charleston		18. ADDRESS 1919 E 21st St.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple traumatic injuries 800 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Subject was struck by a train	
20c. TIME OF INJURY Month, Day, Year 4:55 p.m. 9 9 1967	20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) RR tracks	20f. (City or town) (County) (State) Linthicum AA MD.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 9-11-67	
23c. NAME OF CEMETERY OR CREMATORY Restland		23d. LOCATION (City or town) (County) (State) Clarkston, Ga.	
24. FUNERAL DIRECTOR Fisher, E. Fisher		25a. REC'D BY REGISTRAR SEP 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Jones		22. DATE SIGNED September 10, 1967	

11823

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 216 Severn Ave.,	
3. NAME OF DECEASED (Type or print) Joseph First Middle Last		4. DATE OF DEATH Month September Day 30 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1895
9. AGE (In years last birthday) 72 yrs		10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min 72	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alfred Chase		14. MOTHER'S MAIDEN NAME Sarah T. Goodall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOC. SEC. NO.	
17. INFORMANT Grace Chase		Address 216 Severn Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ac. Pulmonary edema DUE TO (b) Antipsychotic C.V. disease DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 4.5 min.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (as hospital) attended the deceased from Sept. 30, 1967 , to Sept. 30, 1967 , that () () last saw the deceased alive on Sept. 30, 1967 , and that death occurred at 1:30 AM , from causes and on the date stated above			
22a. SIGNATURE Maurice Klawans		22b. DATE SIGNED 1:30 AM	
22c. PHYSICIAN'S NAME (Type) Maurice Klawans, M.D.		22d. ADDRESS 31 Southgate Ave., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10-4-1967	23c. NAME OF CEMETERY OR CREMATORY Orme Lawn	23d. LOCATION (City or town) (County) (State) Annapolis, Md.
24. FUNERAL DIRECTOR William Beesett		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 2 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2. Page 1 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11828

11843

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cape St. Clair Road</u>		d. STREET ADDRESS <u>Cape St. Clair Road</u>	
3. NAME OF DECEASED (Type or print) <u>Priscilla Coates</u>		4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-1888</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY	
10. FATHER'S NAME <u>Hennis Harris</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. MOTHER'S MIDDLE NAME <u>Eliza Green</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		15. SOCIAL SECURITY NO.	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____		17. INTERVA. BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-29-67</u> , 19 <u>67</u> to <u>9-26-67</u> , that (I) (we) last saw the deceased alive on <u>9-21-67</u> , 19 <u>67</u> , and that death occurred at <u>1</u> P.M., from causes and on the date stated above			
22a. SIGNATURE <u>Ardis T. Allen</u>		22b. DATES SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ARDIS T ALLEN</u>		22d. ADDRESS <u>62 Chelmsford St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-29-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fowlers</u>	23d. LOCATION (City or Town) (County) (State) <u>Edgewater MD</u>
24. FUNERAL DIRECTOR <u>William Reese # Anna</u>		25a. REC'D BY REGISTRAR DATE <u>10-2</u> 19 <u>67</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11830

CERTIFICATE OF DEATH

11844

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b 14 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel General Hosp.				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Balto. d. STREET ADDRESS 1534 Carey St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Robb Alonzo Cobb				4. DATE OF DEATH Month Day Year Sept. 27, 1967			
5. SEX M		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-17-11	
9. AGE (in years last birthday) 56 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Julius Cobb				14. MOTHER'S MAIDEN NAME Adline Turner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 245-03-4539		17. INFORMANT Elaine Cobb Address 1534 Carey St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Water-salivary Gland Disease 4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 5, 1967 to Sept 27, 1967 that (I) (we) last saw the deceased alive on Sept 26, 1967 and that death occurred at 9 A.M. from the causes and on the date stated above.							
22a. SIGNATURE F. K. Adams				22b. DATE SIGNED Sept. 29-67		22c. PHYSICIAN'S NAME (Type) F. K. ADAMS	
22d. ADDRESS 1722 N. Caroline St.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-1-67		23c. NAME OF CEMETERY OR CREMATORY Philip High Cem.		23d. LOCATION (city, town or county) (State) North Carolina	
24. FUNERAL DIRECTOR Kelson Funeral Home 1348 Calhoun St.				25a. REC'D BY REGISTRAR SEP 29 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	



11831

CERTIFICATE OF DEATH

11845

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY A.A.Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b 1 Wks	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Ann North Arundel Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clarence A. Cottrill		4 DATE OF DEATH Month Sept Day 20 Year 67	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 15, 1899
9. AGE (In years last birthday) yrs 68		IF UNDER 1 YEAR Months 6 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during previous 12 months) Truck Driver/Retired		10b. KIND OF BUSINESS OR INDUSTRY Westport Mac. Co.	
11. BIRTHPLACE (County & State or foreign country) Williamsport, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME (unknown) Cottrill		14. MOTHER'S MAIDEN NAME (unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 212-03-9422A	
17. INFORMANT Mrs. Shirley A. Howard (daughter)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary artery disease DUE TO Emphysema - Bronchitis DUE TO Cholecystectomy		INTERVAL BETWEEN ONSET AND DEATH. when unknown 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-14-67 , 19 67 , to 9-20- , 19 67 , that (I) (we) last saw the deceased alive on 9-20 , 19 67 , and that death occurred at 11:53 A.M. from causes and on the date stated above.			
22a. SIGNATURE Franz X. Groll		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Franz X. Groll		22d. ADDRESS 11F. Eagan Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/23/67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland
24. FUNERAL DIRECTOR Robert P. Ware		25a. REC'D BY REGISTRAR SEP 25 1967	
25b. REGISTRAR'S SIGNATURE SEP 25 1967		25c. REGISTRAR'S NAME SEP 25 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



11832

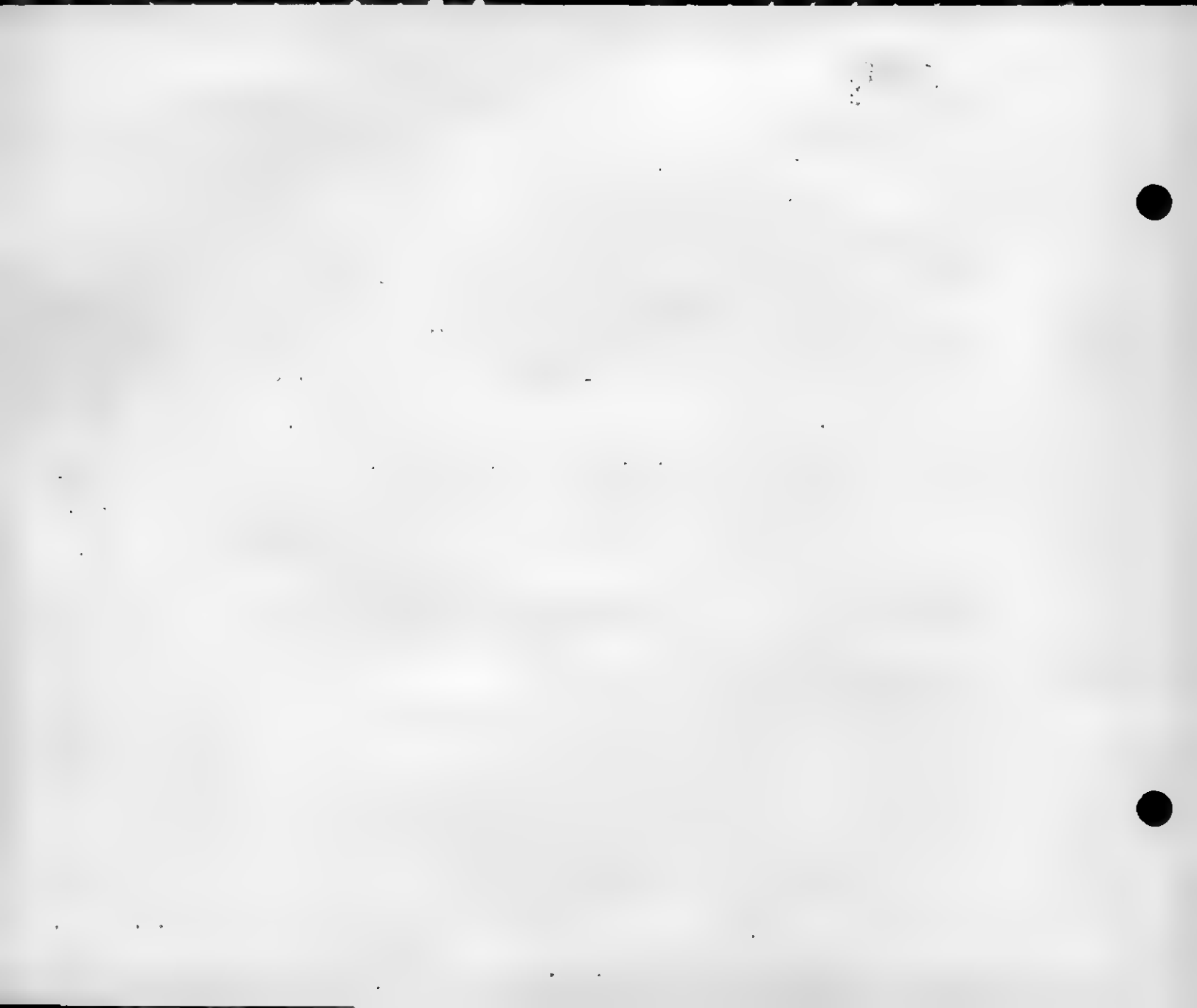
CERTIFICATE OF DEATH

11846

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater, Md</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>1130 Fairhill Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>MELVIN</u> Middle <u>HARRY</u> Last <u>COULTER</u>		4. DATE OF DEATH Month <u>SEPT</u> Day <u>20</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1901</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence C. Coulter</u>		14. MOTHER'S MAIDEN NAME <u>Mary R. Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>578-09-2330A</u>	
17. INFORMANT <u>Mrs. Bessie V. Coulter - same as #2 above</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>CARCINOMA OF BLADDER.</u> DUE TO (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>MAY 23, 1967</u> to <u>SEPT 20, 1967</u> , that (I) (we) last saw the deceased alive on <u>SEPT 2, 1967</u> , and that death occurred at <u>3:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>H. Logan Holtgrewe</u>		22b. DATE SIGNED <u>9/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>H. LOGAN HOLTGREWE</u>		22d. ADDRESS <u>16 MURRAY AVE. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 23, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>All Hallows Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Birdsville A.A. Md.</u>
24. FUNERAL DIRECTOR <u>Bessie V. Coulter</u>		25a. REC'D BY REGISTRAR <u>SEP 25 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Bessie V. Coulter</u>		25c. DATE <u>SEP 25 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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25M 1/67

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CERTIFICATE OF DEATH

11833

71847

1. PLACE OF DEATH a. COUNTY Anne Arundel		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		02-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS 101 Eastern Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lillian		First Lillian		Middle Cschenk		Last Cschenk	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH 9 14 1967	
8. DATE OF BIRTH April 22, 1895		9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore - Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Fontz				14. MOTHER'S MAIDEN NAME Elizabeth Michels			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212 03 8856		17. INFORMANT Henry Cschenk 101 Eastern St. Glen Burnie			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis + 201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) A. S. C. V. D. (c)						INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 7, 1963 to Sept 14, 1967 , that (I) (we) last saw the deceased alive on Sept 14, 1967 , and that death occurred at 2:04 A.M. from causes and on the date stated above							
22a. SIGNATURE Robert Doherty				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 9/14/67	
22c. PHYSICIAN'S NAME (Type) Robert Doherty				22d. ADDRESS 400 Green Bay Trail #113			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9/18/67		23c. NAME OF CEMETERY OR CREMATORY Glen Haven		23d. LOCATION (City or Town) (County) (State) Glen Burnie AA, Md.	
24. FUNERAL DIRECTOR McColly		ADDRESS 130 E. Fort Ave. Balto.		25a. REC'D BY REGISTRAR SEP 18 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11834

11848

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>ANNE</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAUREL</u>		c. LENGTH OF STAY IN 1b <u>LAUREL</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>197A - Brockbridge Road</u>		d. STREET ADDRESS <u>197A - Brockbridge Road</u>	
3. NAME OF DECEASED (Type or print) <u>NORBERT</u>		4. DATE OF DEATH Month <u>9</u> Day <u>28</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/24/28</u>
9. AGE (In years lost birthday) <u>38</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>	
11. BIRTHPLACE (State or foreign country) <u>WAUSAU WISC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ERNEST DAHM</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give branch or dates of service) <u>YES 1946-1947</u>		16. SOCIAL SECURITY NO <u>RT1, Box 197A Laurel</u>	
17. INFORMANT <u>May Viola Dahm Brockbridge Rd</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral aneurysm</u> 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Cerebral aneurysm</u> DUE TO (c) <u>Cerebral aneurysm</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		22. DATE SIGNED <u>9-28-67</u>	
EXAMINER'S NAME (Type) <u>F. L. [Signature]</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street city town or county)	
23a. BURIAL, CREMATION, REMOVAL, etc. <u>Cremation</u>	23b. DATE THEREOF <u>Sept 29 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth's Cemetery</u>	23d. LOCATION (City or town) (County) (State) <u>Rand Pladenburg Md</u>
24. FUNERAL HOME <u>[Signature]</u>		25. RECEIVED BY REGISTRAR <u>[Signature]</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11835

CERTIFICATE OF DEATH

11849

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o STATE Maryland b COUNTY Anne Arundel	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c LENGTH OF STAY IN lb 1 week	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d STREET ADDRESS 107 Glendale Ave.	
3 NAME OF DECEASED (Type or print) Benjamin B. Davidson		4. DATE OF DEATH Month 9 Day 25 Year 1967	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-4-80
9 AGE (In years last birthday) yrs 87		10. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) (Ret.)	11. BIRTHPLACE (County & State, or foreign country) Virginia
10b KIND OF BUSINESS OR INDUSTRY Town-Yale		12. CIT ZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME James R. Davidson		14. MOTHER'S MAIDEN NAME Mary Whorley	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 224-09-0221	
17 INFORMANT Mrs. Roxie B. Schemm		Address Same as Daughter # 2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis with DUE TO impairment of function Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) malnutrition DUE TO hypophosphatemia (c) chronic urinary tract infection			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/18/67 , 19 to 9/25 , 19 67 , that (I) (we) last saw the deceased alive on 9/24 19 67 , and that death occurred at 1:34 M, from causes and on the date stated above			
22a. SIGNATURE B. A. deGuzman		22b DATE SIGNED 9/26/67	
22c. PHYSICIAN'S NAME (Type) B. A. deGuzman, MD.		22d ADDRESS 204 Grain Hwy. S. Glen Burnie, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF Sept. 28/ 67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland
24. FUNERAL DIRECTOR E. B. Browning		25a. REC'D BY REGISTRAR SEP 27 1967	
ADDRESS Singleton Funeral Home Glen Burnie, Maryland		25b REGISTRAR'S SIGNATURE Charles Jones	



11836

CERTIFICATE OF DEATH

11850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jessups</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Employee Md. House of Correction</i>				d. STREET ADDRESS <i>3305 Southern Ave.</i>			
3. NAME OF DECEASED (Type or print) First <i>Harry</i> Middle <i>Edward</i> Last <i>Deets, Sr.</i>				4. DATE OF DEATH Month <i>Sept.</i> Day <i>24</i> Year <i>1967</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 17, 1906.</i>		9. AGE (in years last birthday) yrs <i>61</i>		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer Md. House of Correction.</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Milton Deets</i>				14. MOTHER'S MAIDEN NAME <i>Mary Weber</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>1920--1928</i>		17. INFORMANT <i>Mrs. Clara B. Deets</i>		Address <i>(Same)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction - acute</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1-1</i> , 19 <i>65</i> , to <i>9-23</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4-24</i> , 19 <i>62</i> , and that death occurred at <i>4-24</i> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Sebastian Russo</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <i>9/25/67</i>		22c. PHYSICIAN'S NAME (Type) <i>SEBASTIAN RUSSO M.D.</i>	
22d. ADDRESS <i>5617 Harwood Rd Baltimore Md</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9/28/67.</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cem.</i>		23d. LOCATION (City or town) (County) (State) <i>Baltimore, Md.</i>	
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc Baltimore, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>SEP 26 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>	



CERTIFICATE OF DEATH

11851

11837

1 PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b 11837 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) City - Annapolis d. STREET ADDRESS 113 Ridgely Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bessie First Middle Last DICKSON		4 DATE OF DEATH Month Day Year September 23, 19 67	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH August 1, 1890.
9 AGE (In years last birthday) yrs 77		10 IF UNDER 1 Year Months Days Hours Min. 77	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY Missouri	
11 BIRTHPLACE (County & State, or foreign country) Missouri		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME Leroy Brown		14 MOTHER'S MAIDEN NAME Miller Anderson	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of serv etc) No		16 SOCIAL SECURITY NO 493-38-8308	
17 INFORMANT Bessie Dickson		Address 113 Ridgely Ave.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Perforation of colon. 153.8 DUE TO Cancer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cervical of colon. DUE TO (c) Interval between onset and death None			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 4/25	20f (City or town) (County) (State) 9/23/67
21 I certify that (I) (this hospital) attended the deceased from 9/25 , 19 66 to 9/23/67 , that (I) (we) last saw the deceased alive on September 23, 19 67 , and that death occurred at 10:15 P.M. M, from causes and on the date stated above.			
22a SIGNATURE Genora		22b DATE SIGNED 9/25/67	
22c PHYSICIAN'S NAME (Type) Genora		22d ADDRESS 121 C. H. F. H. AVE. SE. ANNAPOLIS	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9-30-1967	23c NAME OF CEMETERY OR CREMATORY Pine Lawn	23d LOCAT ON (City or Town) (County) (State) Annapolis Md
24 FUNERAL DIRECTOR William Reese		25a DECEASED BY REGISTRAR SEP 27 1967	
25b REGISTRAR'S SIGNATURE James J. J.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

11838

11852

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ANNE ARUNDEL GEN. HOSP.		d. STREET ADDRESS Box 18, Ridge Road BAY MANOR NURSING HOME	
3. NAME OF DECEASED (Type or print) Katherine S. Dowgalski		4. DATE OF DEATH Month Sept Day 6 Year 1967	
5. SEX F	6. COLOR OR RACE CAU	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1875
9. AGE (In years last birthday) 92 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Ret)	
11. BIRTHPLACE (Country, State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Karl Demczynski		14. MOTHER'S MAIDEN NAME Rosley Demerski	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 214-30-6288	
17. INFORMANT Eleanor L. Neil		Address SAME AS #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Pneumonia, right lung DUE TO (c) Cerebral Thrombosis with right hemiparesis			INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Degenerative arthritis, pyelonephritis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 4, 1967 , to Sept 6, 1967 , that (I) (we) last saw the deceased alive on Sept 5, 1967 , and that death occurred at 4:15 AM , from causes and on the date stated above.			
22a. SIGNATURE Charles W. Kinzer		22b. DATE SIGNED Sept 6, 1967	
22c. PHYSICIAN'S NAME (Type) CHARLES W. KINZER, M.D.		22d. ADDRESS 16 MURRAY AVE, ANNAPOLIS, MD 21401	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 9/9/67	23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausokum	23d. LOCATION (City or Town) (County) (State) Woodlawn, MD.
24. FUNERAL HOME R. P. Ware - Singleton Funeral Home		25a. REC'D BY REGISTRAR DATE SEP 11 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

11839

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

77853

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANAPOLIS</u> c. LENGTH OF STAY IN 1b <u>ANAPOLIS</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A. A.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salesville</u>	
3. NAME OF DECEASED (Type or print) <u>William Edward Easton</u> First Middle Last		4. DATE OF DEATH <u>Sept. 24</u> 19 <u>67</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-1918</u> 49 yrs
9. AGE (in years last birthday) <u>49</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u>	
11. BIRTHPLACE (County, State, or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vernon Easton</u>		14. MOTHER'S M A DEN NAME <u>Annie Foote</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>213-05-0028</u>	
17. INFORMANT <u>Henretta Easton</u> Address <u>Salesville, MD.</u>		18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>yearn</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe diabetes mellitus & peripheral vascular disease (double amputee of legs)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of this form)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>Jan</u>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 3</u> 19 <u>67</u> to <u>Sept 24</u> 19 <u>67</u> , that (I) (we) saw the deceased alive on <u>Sept. 3</u> 19 <u>67</u> and that death occurred at <u>11:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u> MD		22b. DATE SIGNED <u>9/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith, MD</u>		22d. ADDRESS <u>Shady Side, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-30-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ebenezer</u>	23d. LOCATION (City or Town) (County) (State) <u>Salesville MD.</u>
24. FUNERAL DIRECTOR <u>William Reeseth</u> ADDRESS <u>Anna, MD.</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1967</u> 25b. REGISTRAR'S SIGNATURE <u>James Judge</u>	



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VR A15 (1)
15M 7-62

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11840 Item #2c & d Film #992 9/10/67 11854											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A. Co.</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u>				c. LENGTH OF STAY in 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>St. Margarets</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BAY MANOR NURSING HOME</u>				d. STREET ADDRESS <u>Rt. #2 Revell Hwy.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>BLANCHE M.</u>		First Middle		4. DATE OF DEATH <u>9 9 1967</u>		Month Day Year		5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-9-1875</u>		9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>PRIEST</u>		14. MOTHER'S MAIDEN NAME <u>WOODWARD</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Nursing Home #1</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>Cholecystitis Chronic acute few days</u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) 20f. (City or town) (County) (State) 21 I certify that (I) (this hospital) attended the deceased from... 19... to... 19... , that (I) (we) last saw the deceased alive on... 19... , and that death occurred at... 19... M, from the causes and on the date stated above. 22a. SIGNATURE <u>B.M. Smith</u> M.D. 22b. DATE SIGNED <u>Sept 9 1967</u> 22c. PHYSICIAN'S NAME (Type) <u>B.M. Smith</u> 22d. ADDRESS <u>SEVERNA PARK, MD.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>9-11-67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Margarets</u> 23d. LOCATION (City, town or county) (State) <u>St. Margarets MD.</u> 24 FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis, Md.</u> 25a. REC'D BY REGISTRAR <u>SEP 13 1967</u> 25b. REGISTRAR'S SIGNATURE <u>John M. Taylor</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
11841											
CERTIFICATE OF DEATH											
71855											
1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital						d. STREET ADDRESS 121 Smith Ave.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) James Ellsworth EMERICK						4 DATE OF DEATH Month September Day 29 Year 19 67					
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH July 12, 1912		9 AGE (In years last birthday) yrs. 55		10 IF UNDER 1 YEAR Months 29 Days 29 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumbing				10b. KIND OF BUSINESS OR INDUSTRY Boat building		11 BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland				12 CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME GROVER EMERICK						14. MOTHER'S MAIDEN NAME LILLIAN BRANZELL					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT MRS. MARY M. EMERICK #2 Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ruptured aortic aneurysm DUE TO (b) hypertensive cardiovascular disease c DUE TO (c) marked arteriosclerosis										INTERVAL BETWEEN ONSET AND DEATH 2 hrs., 10 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (the hospital) attended the deceased from Sept. 29, 19 67 , to Sept. 29, 19 67 that (I) can saw the deceased alive on Sept. 29, 19 67 , and that death occurred at 6:40 PM M. from causes and on the date stated above.											
22a. SIGNATURE Samuel Borssuck, M.D.						22b. DATE SIGNED 10/2/67		22c. PHYSICIAN'S NAME (Type) Samuel Borssuck, M.D.			
22d. ADDRESS Amos Garrett Blvd., Annapolis, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 10-2-1967		23c. NAME OF CEMETERY OR CREMATORY HILLCREST CEM.				23d. LOCATION (City or Town) (County) (State) ANNAPOLIS MD.			
24. FUNERAL DIRECTOR JOHN M. TAYLOR, SONS ANNAPOLIS MD						25a. REC'D BY REGISTRAR OCT 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

11842

CERTIFICATE OF DEATH

11856

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 414 Second St.,	
3. NAME OF DECEASED (Type or print) First Edith Middle Vernon Last EVANS		4. DATE OF DEATH Month September Day 18 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 16, 1896
9. AGE (In years last birthday) 71 yrs		10. UNDER 1 YEAR Months 1 Days 18 Hours 18 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE	
11. BIRTHPLACE (County & State or foreign country) Calvert Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME W^m DANIEL BOYD		14. MOTHER'S MAIDEN NAME MARY PRICILLA DALRYMPLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO	
17. INFORMANT JOHN T. EVANS #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism DUE TO (b) Cerebral myocardial infarction DUE TO (c) Stroke Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) John L. Hedeman attended the deceased from July , 19 63 , to Sept. 18 , 19 67 , that (I) (no) saw the deceased alive on Sept. 18 , 19 67 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE John L. Hedeman		22b. DATE SIGNED 2:30 PM 9/19/67	
22c. PHYSICIAN'S NAME (Type) John L. Hedeman, M.D.		22d. ADDRESS 1407 Forest Drive., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF SEPT 21 1967	23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF CEM. ANNAPOLIS MD	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR JOHN M. TAYLOR - SONS ANNAPOLIS MD		25a. REC'D BY REGISTRAR SEP 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

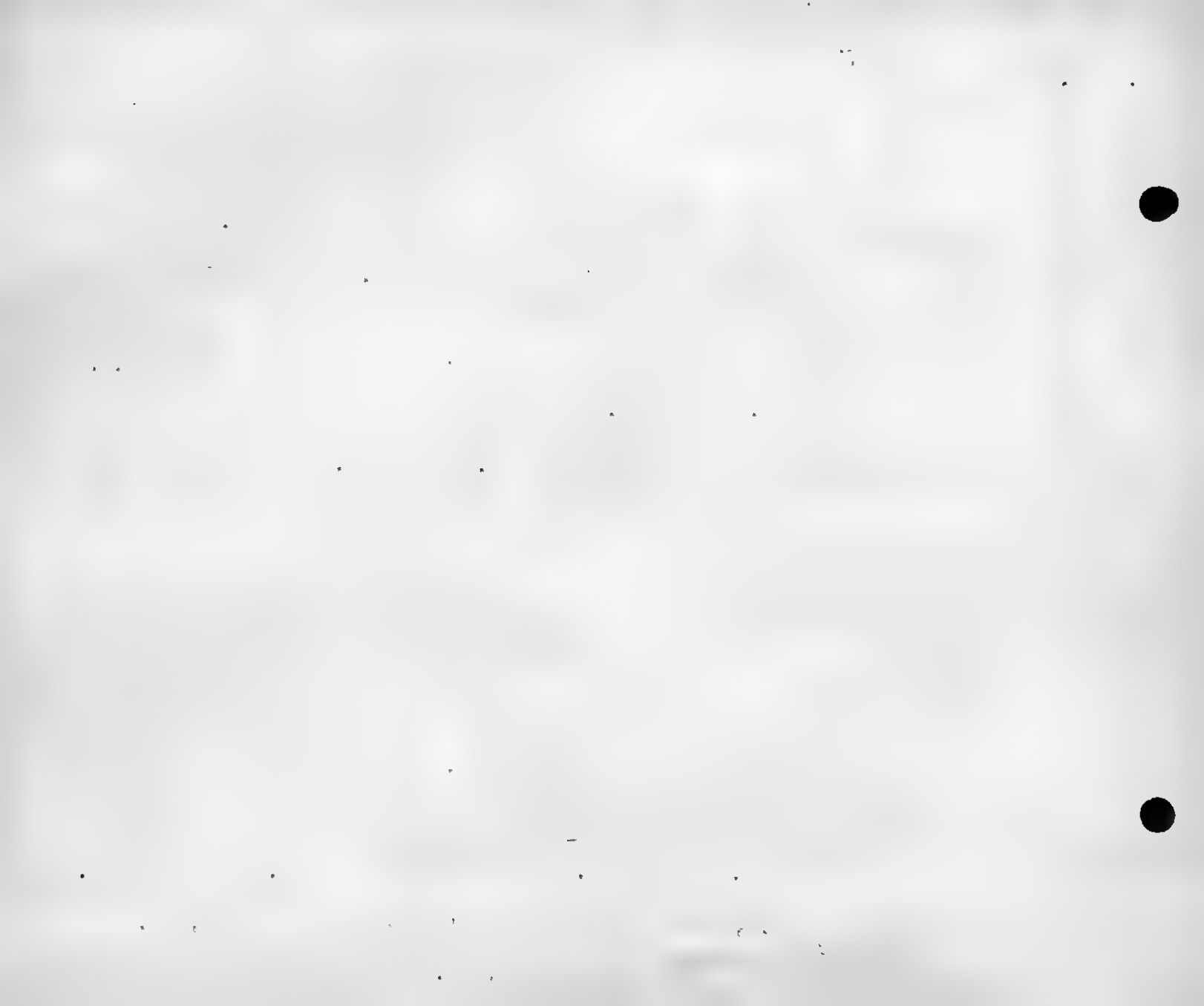
CERTIFICATE OF DEATH

11843

11857

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS 705 Delaware Ave., N/E	
3 NAME OF DECEASED (Type or print) First William Middle Roger Last FARMER Jr.		4. DATE OF DEATH Month September Day 28 Year 1967	
5. SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH June 28, 1914
9. AGE (In years last birthday) yrs 53		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Electrical	
11 BIRTHPLACE (County & State, or foreign country) Baltimore City, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William R. Farmer Sr.		14. MOTHER'S MAIDEN NAME Margaret Medicus	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16 SOCIAL SECURITY NO 212/07/2780	
17 INFORMANT Mrs. Lillian M. Farmer		Address Same as # 2	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiogenic shock DUE TO (b) Acute myocardial infarction DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 3 da.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day Year Hour a.m. 19 p.m. 19	20d INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (1) physician attended the deceased from Sept. 25 , 19 67 , to 9/28 , 19 67 , that (1) yes last saw the deceased alive on 9/28 1967, and that death occurred at 12:45 PM , from causes on and the date stated above.			
22a SIGNATURE Richard N. Peeler		22b DATE SIGNED 9/28/67	
22c PHYSICIAN'S NAME (Type) Richard N. Peeler, M.D.		22d ADDRESS 121 Cathedral St., Annapolis, Md.	
23a BURIAL, CREMATION REMOVAL (Specify) Burial	23b DATE THEREOF Oct. 2, 1967	23c NAME OF CEMETERY OR CREMATORY Glen Haven Mem'l Park	23d LOCATION (City or Town) (County) (State) Glen Burnie, Md.
24. FUNERAL DIRECTOR Robert P. Pura		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 2 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11858

11844

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie (XXXXXX) XXXXXXXX				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie (XXXXXX) XXXXXXXX			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS #410 Forest View Road			
3. NAME OF DECEASED (Type or print) MARY E. FINLEY				4. DATE OF DEATH Sept. 21 19 67			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-16-20		9. AGE (In years lost birthday) 47 yrs		10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical			10b. KIND OF BUSINESS OR INDUSTRY Union News		11. BIRTHPLACE (County & State, or foreign country) Starkville, Colorado		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert Hilliard				14. MOTHER'S MAIDEN NAME Victorial Overdowski			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 220 09 8232		17. INFORMANT Address Mr. Jacob E. Finley (husband) Same As #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Breast & Metastasis DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-16-67 , to 9-21-67 , that (I) (we) lost saw the deceased alive on 9-20-67 , and that death occurred at 8 A.M. from causes and on the date stated above							
22a. SIGNATURE Dr. B. Mac Donald MD				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 25/67		23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR A. T. Singleton				SINGLETON FUNERAL HOME Glen Burnie, Maryland		25a. REC'D BY REGISTRAR DATE SEP 25 1967	
				25b. REGISTRAR'S SIGNATURE William J. Judge			

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CERTIFICATE OF DEATH

11845

11859

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b Washington, D. C.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital, Annapolis, Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edwin Middle Francis Last Fogerty				4. DATE OF DEATH Month Sept. Day 15 Year 19 67			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Sept. 1893		9. AGE (In years lost birthday) 73 yrs	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Col. U. S. A. F.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James Fogerty				14. MOTHER'S MAIDEN NAME Mary Manning			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I WW II			16. SOCIAL SECURITY NO. 577-56-6440		17. INFORMANT Maud E. Fogerty-Wife-Same as Item #2		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) CONGESTIVE HEART FAILURE DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE							INTERVAL BETWEEN ONSET AND DEATH @ 11 mos. 10+ years.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> not While <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) DOA		
20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from DOA , 19 19 , to 19 , that (I) (we) last saw the deceased on 15 SEPT 67 19 19 , and that death occurred at 6:35 A , from causes and on the date stated above.				
22a. SIGNATURE M. F. FORNES, LCDR-MC USN				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 15 Sept. 1967	
22c. PHYSICIAN'S NAME (Type) Naval Hospital, Annapolis, Md.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 9-18-1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION (City or town) (County) (State) Southland Md	
24. FUNERAL DIRECTOR Simmons Bros				25a. REC'D BY REGISTRAR SEP 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11846

CERTIFICATE OF DEATH

11860

1 PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchton</u>		c. LENGTH OF STAY IN 1b <u>lifetime</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <u>Deale - Churchton Road</u>	
3. NAME OF DECEASED (Type or print) <u>Earl</u> First <u>A.</u> Middle <u>Fountain</u> Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-13-1908</u> 59 yrs
9. AGE (In years, months, and days) <u>59</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Mins	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		13. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
14. FATHER'S NAME <u>Benjamin Fountain</u>		15. MOTHER'S MAIDEN NAME <u>Mary Hester Owens</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		17. SOCIAL SECURITY NO. <u>217-07-3390</u>	
18. INFORMANT <u>Mary T. Wills</u> Address <u>Phila. Pa.</u>			
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4201... DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rheumatic heart disease</u> DUE TO (c) <u>Immediate</u> year		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 19)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>59</u> to <u>Sept. 23</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>Sept. 22</u> , 19 <u>67</u> , and that death occurred at <u>7p</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u> M.D.		22b. DATE SIGNED <u>9/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith M.D.</u>		22d. ADDRESS <u>Shady Side, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9.27.67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Franklin</u>	23d. LOCATION (City or town) (County) (State) <u>Deale Md</u>
24. FUNERAL DIRECTOR <u>William Reese #</u>		25a. REC'D BY REGISTRAR <u>SEP 27 1967</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11847

CERTIFICATE OF DEATH

11861

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md.		c. LENGTH OF STAY IN 1b Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital, Annapolis, Md.		d. STREET ADDRESS Apt. 205 Farragut Ct.	
3. NAME OF DECEASED (Type or print) BABY GIRL		4. DATE OF DEATH Month September Day 14 Year 19 67	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 14 Sept. 1967
9. AGE (In years lost birthday) 8 yrs		10. UNDER 1 YEAR Months 8 Days 8	11. UNDER 24 HRS Hours 8 Mins 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Annapolis, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dennis O. French		14. MOTHER'S MAIDEN NAME Gracie ? Clay	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NA.	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) IMMATURITY (7760) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 19 67 , that (I) (we) last saw the deceased alive on 14 Sept. 19 67 , and that death occurred at 1840 M, from causes and on the date stated above.			
22a. SIGNATURE Robert L. Shirley		22b. DATE SIGNED 9/15/1967	
22c. PHYSICIAN'S NAME (Type) R. L. SHIRLEY LCDR MC USN		22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.	
23a. BURIAL CREMATION REMOVAL (Specify)		23b. DATE THEREOF 9/15/1967	
23c. NAME OF CEMETERY OR CREMATORY US Naval Academy		23d. LOCATION (City or town) (County) (State) Annapolis Md.	
24. FUNERAL DIRECTOR Taylor & Sons Funeral Home, Annapolis, Md.		25a. RECEIVED BY REGISTRAR DATE SEP 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



CERTIFICATE OF DEATH

1 PLACE OF DEATH a. <u>Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riverview, Lawnsdowne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		d. STREET ADDRESS <u>2902 Freeway, Riverview</u>	
3 NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>Fritz</u> Last <u>Fritz</u>		4. DATE OF DEATH Month <u>9</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
9. AGE (In years last birthday) <u>78</u> yrs		10. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Leonard Forester</u>		14. MOTHER'S MAIDEN NAME <u>Harriett Garble</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO <u>213-26-1743</u>	
17. INFORMANT <u>Mr. Charles Fritz 369 Rte 2 Elbow Run Md.</u>		18. INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. CAUSE WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion from Fall</u> DUE TO (b) <u>Hypertension Cardiovascular disease</u> DUE TO (c) <u>Spontaneous Aortic aneurysm</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Circumferential Hypertension, Pneumonia, Hemiparesis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/24</u> , 19 <u>67</u> to <u>9/17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/17</u> , 19 <u>67</u> , and that death occurred at <u>7:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Guillermo S. Linsao</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>GUILLERMO S. LINSAO</u>		22d. ADDRESS <u>7308 Furnace Branch Rd. Elbow Run Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/20/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Vincent Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>2930 Belvidere Rd. Md.</u>	
24. FUNERAL DIRECTOR <u>John J. Gowan & Son Inc. 224 N. Hollins St.</u>		25a. REC'D BY REGISTRAR OATE <u>SEP 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J.</u>			

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CERTIFICATE OF DEATH

11863

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-GLEN BURNIE		c. LENGTH OF STAY IN TB 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORTH ARUNDEL HOSPITAL		d. STREET ADDRESS 458 PHIRNE COURT E.	
3. NAME OF DECEASED (Type or print) First Middle Last JAMES GASCOYNE		4. DATE OF DEATH Month Day Year SEPTEMBER 16 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 11, 1874
9. AGE (In years last birthday) 93 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemist	
11. BIRTHPLACE (County & State or foreign country) RICHMOND, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Eliza Wilson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-07-8234	
17. INFORMANT Mrs Elizabexth Van Ormer		Address Glen Burnie, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO (b) Acute Myocardial infarction DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 9/15/67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/11/67 to 9/16/67 , that (I) (we) last saw the deceased alive on 9/15/67 19__, and that death occurred at 6 PM , from causes and on the date stated above.			
22a. SIGNATURE J. B. RAMIREZ MD		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. B. Ramirez MD		22d. ADDRESS 3921 ANNAPOLIS RD Baltimore 27 1672 North Ave. Md Baltimore 12	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/19/67	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City or Town) (County) (State) Baltimore, co. Md.
24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. Baltimore, Md. 21202		25a. REC'D BY REGISTRAR SEP 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11850

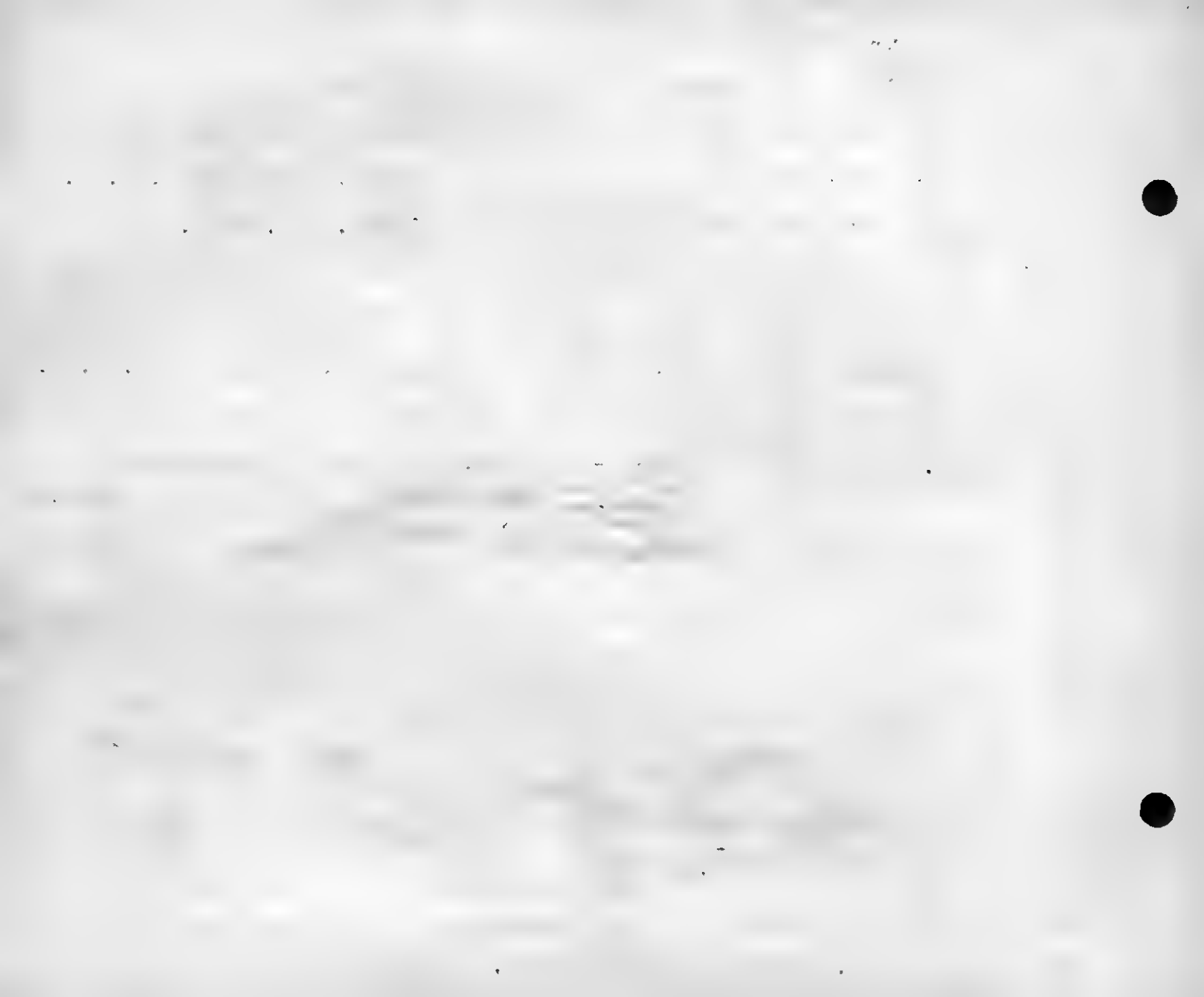
CERTIFICATE OF DEATH

11864

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Marley Burnie		c. LENGTH OF STAY IN TB Marley, Glen Burnie, P. O.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. STREET ADDRESS 1204 B. & A. Blvd.	
3. NAME OF DECEASED (Type or print) First William Middle Adolph Last Gerland		4. DATE OF DEATH Month September Day 9 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/21/1901
9. AGE (In years last birthday) yrs 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Louis Gerland	
14. MOTHER'S MAIDEN NAME Keltz		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.	
16. SOCIAL SECURITY NO 213-10-0742		17. INFORMANT Evelyn Gerland (Wife) As Above	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Heart Failure DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease (c) Arteriosclerotic Heart Disease			INTERVAL BETWEEN ONSET AND DEATH Months Years
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1965 to Sept 1967 , that (I) (we) last saw the deceased alive on Sept 1967 and that death occurred at 1967 M, from causes and on the date stated above.			
22a. SIGNATURE Hilary M. Doherty		22b. DATE SIGNED 9-10-67	
22c. PHYSICIAN'S NAME (Type) H. DOHERTY		22d. ADDRESS M.D. ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/13/67	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Raymond C. Fink		25a. REC'D BY REGISTRAR Glen Burnie, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 11 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



11851

CERTIFICATE OF DEATH

11865

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Glen Burnie		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital		d. STREET ADDRESS Silver Sands North Shore Dr. Rt 1 Box 290		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William J Glass		4. DATE OF DEATH Month September Day 3 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 21, 1886	9. AGE (In years last birthday) 81 yrs	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S. A.		13. FATHER'S NAME George Glass		14. MOTHER'S MAIDEN NAME Hannah Herrman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Carl Glass Rt 1 Box 290 Glen Burnie	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD (c) ASCVD		INTERVAL BETWEEN ONSET AND DEATH 5 minutes years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)	20f. (City or town)	(County)	(State)
21. I certify that (1) (this hospital) attended the deceased from Sept 1, 1966 to Sept 3, 1967 , that (1) (we) last saw the deceased alive on Sept 3, 1967 , and that death occurred at 2:15 P.M. from causes and on the date stated above.					
22a. SIGNATURE David Abramson		M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/5/67	
22c. PHYSICIAN'S NAME (Type) David Abramson		22d. ADDRESS 222 Calto Annapolis Blvd Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/7/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Anne Arundel Co. Md.	
24. FUNERAL DIRECTOR McCully Funeral Home		ADDRESS 237 Patapsco Ave.		25a. REC'D BY REGISTRAR SEP 6 1967	25b. REGISTRAR'S SIGNATURE J. Charles Jones

11852

CERTIFICATE OF DEATH

11866

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville		c. LENGTH OF STAY IN 'b Glen Burnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. STREET ADDRESS Glen Burnie, Md.	
3. NAME OF DECEASED (Type or print) John L. Hall		4. DATE OF DEATH Month Sept. Day 12 Year 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-93
9. AGE (In years lost birthday) yrs 74		10. IF UNDER 1 YEAR Months 12 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles E. Wall		14. MOTHER'S MAIDEN NAME Martha E. Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Patients Chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure 4200 DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Coronary artery disease INTERVAL BETWEEN ONSET AND DEATH None years months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Serious chronic disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 3, 1967 to Sept 12, 1967 that (I) (we) last saw the deceased alive on Sept 12, 1967 , and that death occurred at 6:00 AM , from causes and on the date stated above.			
22a. SIGNATURE Max Frank, M.D.		22b. DATE SIGNED 9/13/67	
22c. PHYSICIAN'S NAME (Type) Max Frank, M.D.		22d. ADDRESS Arundel Medical Group, Glen Burnie, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/15/67	
23c. NAME OF CEMETERY OR CREMATORY John Wesley		23d. LOCATION (City or Town) (County) (State) Statenburg, Md.	
24. FUNERAL DIRECTOR William Reese, Jr. Arundel, Md.		25a. REC'D BY REGISTRAR DATE SEP 13 1967	
		25b. REGISTRAR'S SIGNATURE William Reese, Jr.	

11853

CERTIFICATE OF DEATH

77867

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville c. LENGTH OF STAY IN b. 11 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kuonwood Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS 217 Sunset Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MINNIE Middle B. Last HICKS		4. DATE OF DEATH Month Sept Day 20 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1888
9. AGE (In years last birthday) 78 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (ret.)	11. BIRTHPLACE (County & State, or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME (Unknown) Aydelett	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 229-20-3646A		17. INFORMANT Mr. Robert L. Hicks, Jr.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Left ventricular failure Conditions, if any, which gave rise to immediate cause (b) Cerebrovascular accident (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/31, 1967 to 9/20, 1967 that (I) (we) last saw the deceased alive on 9/20, 1967 , and that death occurred at 10 PM , from the causes and on the date stated above.			
22a. SIGNATURE Max C Frank MD		22b. DATE SIGNED 9/20/67	
22c. PHYSICIAN'S NAME (Type) MAX C FRANK MD		22d. ADDRESS 425 SE Ritchie Hwy Glen Burnie MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 23/67	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City, town or county) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Sigleto Funeral Home		25a. REC'D BY REGISTRAR SEP 25 1967	
25b. REGISTRAR'S SIGNATURE			

1912

1912

1912

1912

CERTIFICATE OF DEATH

11868

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie,		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS Rt. 1 Box 1153	
3 NAME OF DECEASED (Type or print) First Rosie Middle W. Last Hill		4. DATE OF DEATH Month 9 Day 16 Year 1967	
5 SEX F	6 COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12-25-95
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (County & State, or foreign country) Rutland, Md.
13 FATHER'S NAME Nathaniel Hawkins		14 MOTHER'S MAIDEN NAME Lillian Spriggs	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO	17 INFORMANT Evelyn Hill Odenton
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardio Vascular Accident DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis?			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/8/67 , 19 to 9/16 , 1967 that (I) (we) last saw the deceased alive on 9/16 , 1967, and that death occurred at 10:30 M, from causes and on the date stated above.			
22a. SIGNATURE J.B. Ramirez		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J.B. RAMIREZ		22d. ADDRESS 3927 ANN ARUNDEL RD Route 21 1672 NORTH BOURNE RD Bldg 12	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b DATE THEREOF 9-14-67	23c NAME OF CEMETERY OR CREMATORY MT Tabor	23d LOCATION (City or Town) (County) (State) Chestersfield Md
24 FUNERAL DIRECTOR William Reese		25a REC'D BY REGISTRAR SEP 13 1967	
		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11855

CERTIFICATE OF DEATH

11869

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>326 S. East Ave</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Edward Hoffman</u> First Middle Last		4. DATE OF DEATH <u>Sept 16</u> 19 <u>67</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 17</u> 19 <u>05</u> yrs.
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Bruno Hoffman</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Milberger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-10-1372</u>	
17. INFORMANT <u>Hospital Records</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO <u>Post Encephalitic Parkinsonism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Brain Syndrome due to the above.</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Allegedly Beaten</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Allegedly Beaten</u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, wire bridge, etc.) <u>Crownsville Hospital</u>	20f. CITY OR TOWN (County) (State) <u>Crownsville Md</u>
21. I certify that (I) (this hospital) attended the deceased from <u>9/16</u> 19 <u>67</u> to <u>9/16</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/16</u> 19 <u>67</u> , and that death occurred at <u>2:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Lincoln Henry Mepp MD</u>		22b. DATE SIGNED <u>9/16/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lincoln Henry Mepp MD</u>		22d. ADDRESS <u>Crownsville State Hospital, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9-19-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Queto - Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Balto.</u>
24. FUNERAL DIRECTOR <u>Thelma D. Hoffmann</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Justice</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11856

11870

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 603 Dreams Landing e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3 NAME OF DECEASED (Type or print) First Middle Last Warren Clifton HOLSTON				4. DATE OF DEATH Month Day Year September 25 19 67					
5 SEX Male		6 COLOR OR RACE White		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 12, 1886		9 AGE (in years lost birthday) 81 yrs F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Commercial Artist				10b KIND OF BUSINESS OR INDUSTRY Outdoor Advertising		11 BIRTHPLACE (County & State or foreign country) Maryland		12 CITIZEN OF WHAT COUNTRY? U. S.	
13 FATHER'S NAME William H. Holston				14. MOTHER'S MAIDEN NAME Lucinda Myers					
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No				16 SOCIAL SECURITY NO 215-07-0953		17 INFORMANT Address Lucinda Langley 603 Dreams Landing			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CVA; Acute myocardial infarction (b) Severe ASCVD (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO DUE TO								INTERVAL BETWEEN ONSET AND DEATH ± 2-3 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic pneumonia; Cardiac arrest; Rib fractures; Pneumothorax								19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (.) (this hospital) attended the deceased from Aug. 19 67, to Sept 25, 19 67, that (I) (we) last saw the deceased alive on 9-25 19 67 and that death occurred at 4:50 P.M. from causes and on the date stated above									
22a SIGNATURE Peter F. Verkouw						ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> M.D.		22b DATE SIGNED 9-26-67	
22c. PHYSICIAN'S NAME (Type) Peter F. Verkouw M. D.						22d ADDRESS 1407 Forest Drive, Annapolis, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b DATE THEREOF 9/26/67		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d LOCATION (City or Town) (County) (State) Washington 18, D.C.		
24. FUNERAL DIRECTOR Charles F. Bell Jr. ADDRESS Hopping Funeral Home Annapolis, Md. 21401						25a REC'D BY REGISTRAR DATE SEP 28 1967		25b REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

CERTIFICATE OF DEATH

11857

11871

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GLEN BURNIE</u>		c. LENGTH OF STAY IN 1b <u>7 months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>NORTH ARUNDEL CONVALESCENT CENTER</u>				d. STREET ADDRESS <u>811 ST. PAUL ST.</u>			
3 NAME OF DECEASED (Type or print) <u>VIRGINIA DARE HOOD</u>				4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>27</u> Year <u>1967</u>			
5 SEX <u>FEMALE</u>	6 COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 11, 1910</u>	9 AGE (in years last birthday) <u>56</u> yrs	10. UNDER 1 YEAR Months <u> </u> Days <u> </u>		11. UNDER 24 HRS Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Prvt. home</u>		11 BIRTHPLACE (County & State, or foreign country) <u>ELKINS, WEST VIRGINIA</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM ?</u>				14. MOTHER'S MAIDEN NAME <u>LILLIAN BLAKEMORE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-24-4167</u>		17. INFORMANT <u>Hosp Records - I.D.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized carcinoma left ventricular failure</u> DUE TO (b) <u>Carcinomatous Generalized</u> DUE TO (c) <u>Carcinoma of Rectum</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Months</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 9</u> , 19 <u>67</u> to <u>Sept 27</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Sept 27</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above							
22a. SIGNATURE <u>Max C Frank MD</u>				22b. DATE SIGNED <u>9/28/67</u>		22c. PHYSICIAN'S NAME (Type) <u>MAX C FRANK MD</u>	
22d. ADDRESS <u>425 SE 14th Ave</u>		22e. ADDRESS <u>425 SE 14th Ave</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>		23d. LOCATION (City or town) (County) (State) <u>Woodlawn, Baltimore, Md</u>	
24. FUNERAL DIRECTOR <u>Robert S. Bannan</u>				25. REC'D BY REGISTRAR <u>ACT 2</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11856

11872

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>1 year 2 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>21</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>304 N. Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Zeno G. Howard</u>		4 DATE OF DEATH Month <u>9</u> Day <u>24</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>7/21/07</u>
9 AGE (In years last birthday) <u>60</u> yrs.		10 IF UNDER 1 YEAR Months <u>19</u> Days <u>6</u> Hours <u>7</u> Min <u>1</u>	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>David Howard</u>		14. MOTHER'S MAIDEN NAME <u>Cora Rouse</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>Crownsville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension, alcoholic D.T.</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18)	
20c TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> , 19 <u>66</u> , to <u>9/24</u> , 19 <u>67</u> , that (I) (we) lost the deceased alive on <u>9/24</u> , 19 <u>67</u> , and that death occurred at <u>7:30</u> M., from causes and on the date stated above.			
22a SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>9/25/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL (CREMATION, REMOVAL) (Specify)	23b. DATE THEREOF <u>10-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>
24 FUNERAL DIRECTOR <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>OCT 6 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11859

CERTIFICATE OF DEATH

11873

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this page and file it with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY A. A.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel General Hospital		d. STREET ADDRESS Forest Glen Dr., Rt. 7, Box 281	
3. NAME OF DECEASED (Type or print) JOSEPH D. HUPFL, Sr.		4. DATE OF DEATH Month September Day 15 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 3, 1919
9. AGE (In years last birthday) 48 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) plumber		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (County & State, or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nicholas Hupfl		14. MOTHER'S MAIDEN NAME Catherine Barber	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.II		16. SOCIAL SECURITY NO 217-01-6321	
17. INFORMANT Mary E. Hupfl - same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. Myocardial Infarction IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD & Myocardial Ischemic (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/1/67 , 19__, to 8/14/67 , 19__, that (I) (we) last saw the deceased alive on 8/14/67 , 19__, and that death occurred at 5:10 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Andrew R. Sosnowski		22b. DATE SIGNED Sept. 15, 1967	
22c. PHYSICIAN'S NAME (Type) Andrew R. Sosnowski, M.D.		22d. ADDRESS 4016 Ritchie Hwy., Baltimore 21225	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 18, 1967	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hwy., Baltimore		25a. REC'D BY REGISTRAR SEP 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11860

CERTIFICATE OF DEATH

11874

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b Edgewater			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Anne Arundel General Hospital				d. STREET ADDRESS Rt 3 Box 865			
3. NAME OF DECEASED (Type or print) First Middle Last Esther D. Ihrig				4. DATE OF DEATH Month Day Year Sept. 9 1967			
5. SEX female	6. COLOR OR RACE cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Mar. 23, 1905	9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY public school		11. BIRTHPLACE (County & State, or foreign country) Bradford, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Milton Duell				14. MOTHER'S MAIDEN NAME Susie Davis			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-26-8257		17. INFORMANT Harvey W. Ihrig - same as #2 above		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Pancreatitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Diabetic Mellitus</u> DUE TO (c) <u>Hypertensive cardiac & vascular disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 8 days
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/9, 1967, to 9/16, 1967, that (I) (we) last saw the deceased alive on 9/9, 1967, and that death occurred at M. from the causes and on the date stated above.							
22a. SIGNATURE Guillermo S. Linsao				22b. DATE SIGNED 9/11/67			
22c. PHYSICIAN'S NAME (Type) Guillermo S. Linsao, M.D.				22d. ADDRESS 7308 Furnace Branch Rd. Glen Burnie Md. 21061			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 13, 1967		23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR HOPPING FUNERAL HOME				25a. REC'D BY REGISTRAR DATE SEP 14 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jager	

11861

CERTIFICATE OF DEATH

11875

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>304</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY in 1b <u>7 years</u>		d. STREET ADDRESS <u>1421 Lexington Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George Jackson</u>		4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 10/1922</u>
9. AGE (in years last birthday) <u>45</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u> Hours <u>67</u> M.n.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nanley Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Hooper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Hospital Records, Crownsville Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cirrhosis of liver; alcoholism Chronic Brain Syndrome</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (1) (this hospital) attended the deceased from <u>3/23</u> , 19 <u>60</u> , to <u>9/7</u> , 19 <u>67</u> , that (4) (we) last saw the deceased alive on <u>9/7</u> , 19 <u>67</u> , and that death occurred at <u>7:15</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>9/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Catharine Cem. Center Hill Md.</u>	23d. LOCATION (City or Town) _____ (County) _____ (State) _____
24. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>SEP 13 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11862

CERTIFICATE OF DEATH

11876

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN TB 19 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		e. STREET ADDRESS 1059 Myrtle Avenue	
3. NAME OF DECEASED (Type or print) Arabella		4. DATE OF DEATH Month 9 Day 7 Year 1967	
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/8/94
9. AGE (In years lost birthday) 73 yrs		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10b. KIND OF BUSINESS OR INDUSTRY Domestic Work	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, Crownsville Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Dehydration and Inanition Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) surgically Schizophrenic Reaction TBC(?) old intestinal obstruction repaired			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of form 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/26/ , 19 48 , to 9/7/ , 19 67 , that (I) (we) last saw the deceased alive on 9/7/ , 19 67 , and that death occurred at 12:05 AM, from causes and on the date stated above			
22a. SIGNATURE L. Benedict, M.D.		22b. DATE SIGNED 9/7/67	
22c. PHYSICIAN'S NAME (Type) L. Benedict, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/11/67	23c. NAME OF CEMETERY OR CREMATORY Bellevue Mem. Park	23d. LOCATION (City or town) (County) (State) Baltimore Co. Md
24. FUNERAL DIRECTOR Robert E. Miller 3035 W. North Ave.		25. REC'D BY REGISTRAR SEP 15 1967	
25b. REGISTRAR'S SIGNATURE Judge		25c. REGISTRAR'S SIGNATURE Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11863 CERTIFICATE OF DEATH 77877

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.Co			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Severna Park				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Earleigh Hgts Rt 2 Box 400				d. STREET ADDRESS Earleigh Hgts Rt2 Box 400			
3. NAME OF DECEASED (Type or print) First Rosa Middle Lee Last Jennings				4. DATE OF DEATH Month Sept Day 19 Year 1967			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-12-1896	
9. AGE (in years last birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (County & State, or foreign country) Amelia Co, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Thomas Jackson			
14. MOTHER'S MAIDEN NAME Henrietta ?				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO. *****				17. INFORMANT Beatrice Brown 62 Demarest St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A.C.V.D. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 1958 , 19, to 1967 , 19, that (I) (we) last saw the deceased alive on 9-16 1967 , and that death occurred at 6 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert R. Hahn M.D.				22b. DATE SIGNED 9-19-67			
22c. PHYSICIAN'S NAME (Type) Robert R. Hahn				22d. ADDRESS Severna Park, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-23-67		23c. NAME OF CEMETERY OR CREMATORY Asbury Town neck		23d. LOCATION (City, town or county) (State) A.A. Co Md	
24. FUNERAL DIRECTOR C.E. Hicks, 111 Annapolis, Md				25a. REC'D BY REGISTRAR SEP 25 1967			
25b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #1d Film #3392 9/3/67 ph

FOR STATE
HEALTH DEPT

11864

11878

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Meade c. LENGTH OF STAY IN 1b Washington d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kimbrough Army Hospital				2 USUAL RESIDENCE (Where deceased lived, f institution Residence before admission) a. STATE D.C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4331 DuBois Place S.E. e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First DONALD Middle D. Last JOHNSON				4 DATE OF DEATH Month September Day 2 Year 19 67			
5 SEX Male		6 CO. OR OR RACE Negro		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8 DATE OF BIRTH 4/2/39	
9 AGE (n years last birthday) 28 yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) Nurse Aid		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Willie Johnson		14. MOTHER'S MAIDEN NAME Annie Mae McNeil		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO		17. INFORMANT Annie Mae Rollins, Washington, D.C.		Address		18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lacerations of heart and right lung 823.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) Crushing injury of chest DUE TO (c) C	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Driver of auto - collided with tree	
20c. TIME OF INJURY Month Day, Year Hour a.m. 2:00 xx 9-2- 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) street		20f. (City or town) (County) (State) Fort Meade Anne Arundel	
21 I certify that I took charge of the remains described above held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				22. DATE SIGNED September 2, 1967		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 9/7/67		23c. NAME OF CEMETERY OR CREMATORY Columbia		23d. LOCATION (City or Town) (County) (State) Columbia, S.C.		24 FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St	
25a. REC'D BY REG STRAR SEP 5 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS (Street, city, town, or county)		25d. ACTUAL SIGNATURE <i>Charles S. Springate</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. It may delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 103. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



11865

CERTIFICATE OF DEATH

11880

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN lb /////	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		d. STREET ADDRESS 201 Mission Street	
3. NAME OF DECEASED (Type or print) First Gladys D. Johnson		4. DATE OF DEATH Month September 22 19 67	
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-13-04
9. AGE (In years lost birthday) 65 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry T. Donaldson		14. MOTHER'S MAIDEN NAME Bertha Suehle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no none		16. SOCIAL SECURITY NO Unknown	
17. INFORMANT Mrs. Helen Gross (sister)		Address Glen Burnie, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Death by cardiac infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHF</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour of day p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9/15/67, 19, to 9/22/67, 19, that (I) (we) last saw the deceased alive on 9/21/67, 19, and that death occurred at 12:50 PM from causes and on the date stated above			
22a. SIGNATURE J. B. Ramirez		22b. DATE SIGNED 9/22/67	
22c. PHYSICIAN'S NAME (Type) J. B. RAMIREZ		22d. ADDRESS 3527 ANNA POLK RD Balt 21 1672 NORTHBOURNE RD Balt 12	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 25/ 67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.	23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland
24. FUNERAL DIRECTOR Singleton Funeral Home		25a. REC'D BY REGISTRAR DATE SEP 27 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



CERTIFICATE OF DEATH

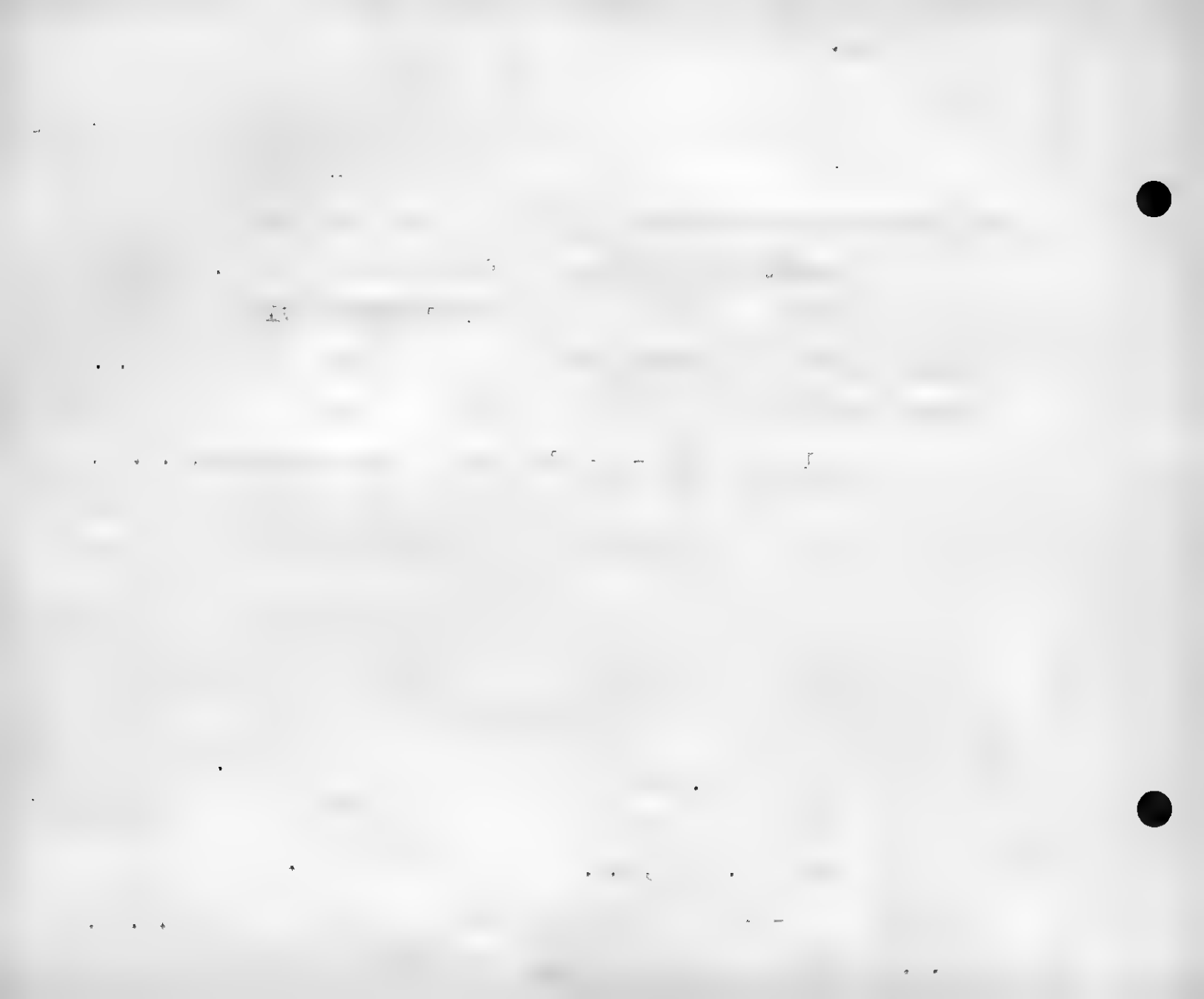
11881

11266

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 15 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Muddy Creek Road	
3. NAME OF DECEASED (Type or print) Samuel William JOHNSON		4. DATE OF DEATH Month Sept. Day 30 Year 19 67	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1896
9. AGE (in years last birthday) 71		10. IF UNDER 1 YEAR Months 1 Days 19 Hours 67 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction		10b. KIND OF BUSINESS OR INDUSTRY *****	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Johnson		14. MOTHER'S MAIDEN NAME Molly Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW 1		16. SOCIAL SECURITY NO. 214-05-1417	
17. INFORMANT Walter Johnson, Harwood, A.A.Co, Md		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Internal obstruction, cause unknown? DUE TO (b) Incarcerated pt. inguinal hernia? DUE TO (c) years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) Willard F. Smith attended the deceased from Jan , 19 67 , to Sept. 30 19 67 , that (I) was saw the deceased alive on Sept. 30 19 67 , and that death occurred at 8:50 PM from causes and on the date stated above.			
22a. SIGNATURE Willard F. Smith		22b. DATE SIGNED 10/2/67	
22c. PHYSICIAN'S NAME (Type) Willard F. Smith, M.D.		22d. ADDRESS Shady Side, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-5-1967	23c. NAME OF CEMETERY OR CREMATORY Church of God	
23d. LOCATION (City or Town) (County) (State) A.A.Co. Md		23e. REC'D BY REGISTRAR OCT 5 1967	
24. FUNERAL DIRECTOR C.E. Hicks, 111		25. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11867		Item #1d Film #1193 9-12-67		71882							
1. PLACE OF DEATH a. COUNTY <u>AA Co</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Shady Side</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Private Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>PENNA</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASHINGTON</u> d. STREET ADDRESS <u>650 N. WADE AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>STUART</u> Middle <u>CURTIS</u> Last <u>JOHNSON</u>						4. DATE OF DEATH Month <u>SEPT</u> Day <u>15</u> Year <u>1967</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 24, 1903</u>		9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u></u> Days <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>STUART CLARK JOHNSON</u>						14. MOTHER'S MAIDEN NAME <u>BERTHA CURTIS</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>178-09-0177</u>		17. INFORMANT <u>VALENTIA JOHNSON</u>		Address <u>WASHINGTON, PA.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Hypertensive cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, <u>over 20 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15, 1967</u> to <u>Sept 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 15, 1967</u> , and that death occurred at <u>11 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Willard F. Smith</u>						22b. DATE SIGNED <u>Sept 16, 67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith, MD</u>						22d. ADDRESS <u>Shady Side, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>9-19-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON, PENNA</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>HARDETT</u>						ADDRESS <u>Galesville, Md</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

11879

11868

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

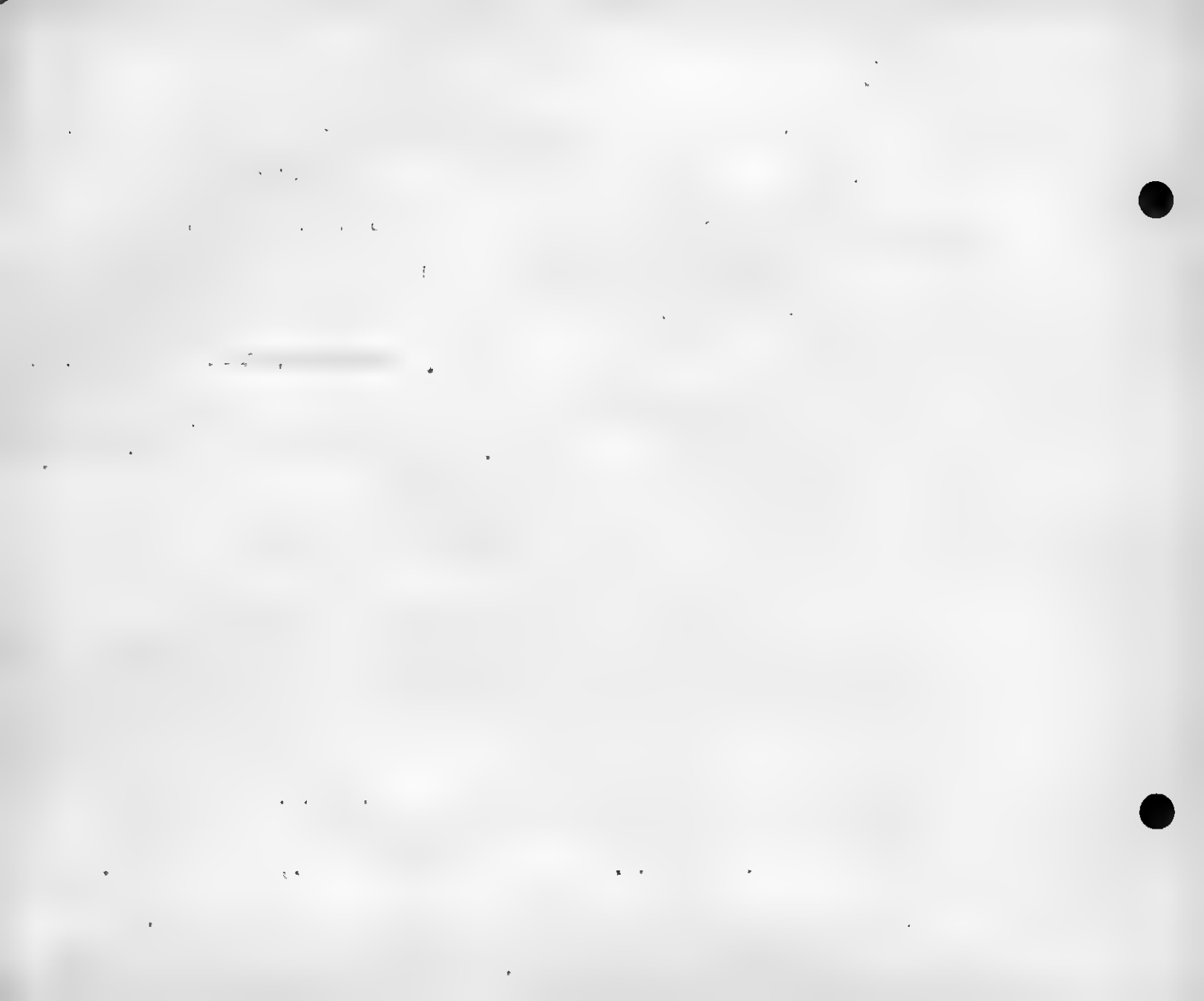
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>02.1</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold, Maryland</u> d. STREET ADDRESS <u>Joyce Lan</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First Middle Last</u> <u>Louisa DENSON JOYCE</u>		4. DATE OF DEATH Month <u>September</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 27, 1900</u> <u>66</u> yrs
9. AGE (In years lost, in days) <u>66</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>BERNARD W. DENSON</u>		14. MOTHER'S MAIDEN NAME <u>NERA T. LAMORE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>214 260955</u>	
17. INFORMANT <u>DENSON W. Higgins</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock</u> 570.5 DUE TO (b) <u>Intestinal obstruction</u> DUE TO (c) <u>Fibrous band compressing the ileum.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 19 67</u> to <u>Sept 24 19 67</u> , that (I) (was) last saw the deceased alive on <u>4/24</u> 19 <u>67</u> , and that death occurred at <u>10:50 PM</u> from causes and on the date stated above			
22a. SIGNATURE <u>Francis I. Codd</u>		22b. DATE SIGNED <u>9-26-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS I. Codd</u>		22d. ADDRESS <u>Severna Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9-27-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial</u>	23d. LOCATION (City or town) (County) (State) <u>Millersville Md.</u>
24. FUNERAL DIRECTOR <u>John M. Layton Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 2 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11869		CERTIFICATE OF DEATH	
17883			
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 2606 Green Briar Lane	
3. NAME OF DECEASED (Type or print) Dorothy Frances KENDRICK		4. DATE OF DEATH Month September Day 7 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 25, 1899
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 67 Min	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Housewife	
12. BIRTHPLACE (County & State, or foreign country) Chicago Ill.		13. CITIZEN OF WHAT COUNTRY? U. S.	
14. FATHER'S NAME William Edward Barrington		15. MOTHER'S MAIDEN NAME Elizabeth Barrington	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		17. SOCIAL SECURITY NO. no	
18. INFORMANT Mrs. Emily Reichert		Address 2606 Greenbr- ar Lane, Annapolis Md.	
19. CAUSE OF DEATH (Enter only one cause per ne for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction + 301 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease (c) Systolic Hypertension		INTERVAL BETWEEN ONSET AND DEATH 3 days 5 YEARS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (th's hospital) attended the deceased from June , 19 53 , to 9 SEPT , 19 67 , that (I) (we) last saw the deceased alive on 7 SEPT , 19 67 , and that death occurred at 6:45 P.M. from causes and on the date stated above.			
22a. SIGNATURE Edward S. Beck M.D.		22b. DATE SIGNED 9/8/67	
22c. PHYSICIAN'S NAME (Type) Edward S. Beck, M.D.		22d. ADDRESS 73 Franklin St., Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept 11 1967	23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery	23d. LOCATION (City or Town) (County) (State) Annapolis, Md.
24. FUNERAL DIRECTOR Beall Funeral Home		25a. REC'D BY REGISTRAR SEP 13 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1 67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11871

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11885

1 PLACE OF DEATH a. COUNTY <u>P.A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANCO.</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN ID <u>1111111</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - Marchwood Hospital</u>		e. STREET ADDRESS <u>1013 - N. York Road.</u>	
3 NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>A</u> Last <u>Kinsey</u>		4 DATE OF DEATH Month <u>9</u> Day <u>16</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH <u>April 29, 1920</u>
9. AGE (In years last birthday) <u>47</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10. IF UNDER 1 YEAR Months <u>12</u> Days <u>19</u> Hours <u>27</u> Min <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rigger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Beth Steel</u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Leo J. Kinsey, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Elizabeth Warfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW-11</u>		16 SOCIAL SECURITY NO <u>215-07-7100</u>	
17 INFORMANT (Brother) <u>Mr. Raymond Kinsey</u>		18 ADDRESS <u>7808 Harbor Dr. Orchard Beach Balto. 21226</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Coronary Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Kinsey</u> M.D.		22. DATE SIGNED <u>9-16-67</u>	
EXAMINER'S NAME (Type) <u>E. Kinsey</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town or county)		Address (Street, city, town or county)	
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk.</u>	23d. LOCATION (City or Town) County, (State) <u>Glen Burnie, Maryland</u>
24 FUNERAL DIRECTOR <u>Richard V. Singleton</u>		25a. REC'D BY REGISTRAR <u>SEP 19 1967</u>	
Address <u>Glen Burnie, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11872

CERTIFICATE OF DEATH

11886

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, not later than 2 hours after death.

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL <input checked="" type="checkbox"/> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MD b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CROWNVILLE		c. LENGTH OF STAY IN IB Since 8/14/67	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CROWNVILLE State Hospital		e. STREET ADDRESS 4820 GREENCREST ROAD	
3 NAME OF DECEASED (Type or print) ARTHUR REED KIRBY		4 DATE OF DEATH Month 9 Day 3 Year 1967	
5 SEX M	6 COLOR OR RACE N	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 10/13/1890
9 AGE (In years lost birthday) 76 yrs		10 IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min 0	
11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		12 KIND OF BUSINESS OR INDUSTRY TRANSIT	
13 BIRTHPLACE (County & State, or foreign country) BALTIMORE MD		14 CITIZEN OF WHAT COUNTRY USA	
15 FATHER'S NAME JAMES KIRBY		16 MOTHER'S MAIDEN NAME ANNA SHIELDS	
17 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		18 SOCIAL SECURITY NO 213-10-2505A	
19 INFORMANT HOSPITAL RECORDS		Address	
20 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4500 PNEUMONIA IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO CHRONIC BRAIN SYNDROME ASS. E. ARTERIOSCLEROSIS (c) DUE TO since admission		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
21 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
23 TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		24 INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25 PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26 (City or town) (County) (State)	
27 I certify that (this hospital) attended the deceased from 8/14/67 , 19 to 9/3/67 , 19, that (we) lost the deceased alive on 9/3/67 , 19, and that death occurred at MD , from causes and on the date stated above.			
28 SIGNATURE Benjamin M.D.		29 DATE SIGNED 9/3/67	
30 PHYSICIAN'S NAME (Type) L. BENEDICT M.D.		31 ADDRESS Crownville State Hospital	
32 BURIAL, CREMATION, REMOVAL (Specify) BURIAL		33 DATE THEREOF 9/7/67	
34 NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		35 LOCATION (City or Town) (County) (State) A.A. Co., Md.	
36 FUNERAL DIRECTOR McCully Funeral Home		37 ADDRESS 30 E Fort Ave	
38 REC'D BY REGISTRAR SEP 5 1967		39 REGISTRAR'S SIGNATURE Charles Jones	

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
GM 1/67

11870

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11884

1 PLACE OF DEATH a COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE Maryland b COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Margaret's		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Margaret's	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) White Hall Road		d. STREET ADDRESS White Hall Road	
3 NAME OF DECEASED (Type or print) First OLIVER Middle K. Last KNAUTH		4 DATE OF DEATH Month September Day 28 Year 1967	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8 DATE OF BIRTH 6 JUNE 1912
9 AGE (In years last birthday) yrs 55		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WRITER	
10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country) NEW YORK	
12 CITIZEN OF WHAT COUNTRY? U.S.A.		13 FATHER'S NAME OSWALD KNAUTH	
14. MOTHER'S MAIDEN NAME ANNA CLEMENS		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16 SOCIAL SECURITY NO		17 INFORMANT ROBT. C. CABOT, 2 PLEASANT FL., J. NATUCK, MASS.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertensive and arteriosclerotic cardiovascular disease 443 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		22. DATE SIGNED September 28, 1967	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	23b. DATE THEREOF 2 OCT. 67	23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CREM.	23d. LOCATION (City or Town) (County) (State) BALTO, MD.
24 FUNERAL DIRECTOR ULLRICH FUNERAL HOME, BALTO., MD.		25a. REC'D BY REGISTRAR DATE OCT 4 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

11878

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11887

1. PLACE OF DEATH e. COUNTY <u>A.A. Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MD</u> b. COUNTY <u>A.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>104 Hatton Drive</u>		d. STREET ADDRESS <u>104 Hatton Drive</u>	
3. NAME OF DECEASED (Type or print) <u>FRANK JOSEPH KOPECKY</u>		4. DATE OF DEATH <u>9-16 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-27-21</u>
9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Control negotiator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NASA</u>	
11. BIRTHPLACE (State or foreign country) <u>NEBRASKA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank J. Kopecky</u>		14. MOTHER'S MAIDEN NAME <u>Emma Kutich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>507124664</u>	
17. INFORMANT <u>Mrs. Martha Ellen Kopecky</u> Address <u>above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun shot skull - R</u> DUE TO <u>Leuprolid Region</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Gun shot wound - Left Inflamed.</u>	
20c. TIME OF INJURY Month, Day, Year <u>9-16 1967</u> Hour <u>9</u> a.m. <u>p.m.</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Severna Park</u> (County) <u>AA</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DATE SIGNED <u>9-16-67</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-21-67</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l</u>		22d. LOCATION (City, town, or county) <u>Arlington Va.</u>	
23. FUNERAL DIRECTOR <u>Robert S. Barranco</u> ADDRESS <u>Severna Park, MD</u>		24a. REC'D BY REGISTRAR <u>SEP 25 1967</u>	
24b. REGISTRAR'S SIGNATURE <u>Robert S. Barranco</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11874

11888

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> c. LENGTH OF STAY IN 1b <u>4 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>14 Broadship Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Effie</u> First Middle Last 4. DATE OF DEATH <u>9/19/67</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>7/18/94</u> 9. AGE (in years last birthday) <u>73</u> 10. IF UNDER 1 YEAR Months Days Hours Min. <u>19</u> 11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u> 11. FATHER'S NAME <u>ROBERT BIJEL</u> 12. MOTHER'S MAIDEN NAME <u>MARY H. RETALLICK</u>		13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u> 14. SOCIAL SECURITY NO <u>unknown</u> 15. INFORMANT <u>Hospital Records, Crownsville Maryland</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute ulcerative cystitis</u> DUE TO (b) <u>Acute bilateral pyelonephritis with abscess formations</u> DUE TO (c) <u>Intertrochanteric fracture, left hip (operated)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with Cerebral Arteriosclerosis, Anemia, moderate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6000</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>10/23</u> , 19 <u>63</u> , to <u>9/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/19</u> , 19 <u>67</u> , and that death occurred at <u>6:30 A.M.</u> from causes and on the date stated above	
22a. SIGNATURE <u>C. Dorkan</u> 22c. PHYSICIAN'S NAME (Type) <u>C. Dorkan, M.D.</u>		22b. DATE SIGNED <u>9/20/67</u> 22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Sept 22/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u> 23d. LOCATION (City or town) (County) (State) <u>Balto Co Md</u>		24. FUNERAL DIRECTOR <u>William L. Linnell Home Dundalk Md</u> 25a. REC'D BY REGISTRAR <u>SEP 25 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11875

CERTIFICATE OF DEATH

11889

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BURNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW BURNIE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. BOX 462</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CROWNSVILLE STATE HOSP.</u>		d. STREET ADDRESS <u>Glen Burnie</u>	
3 NAME OF DECEASED (Type or print) <u>STELLA B. LEMONS</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-26-83</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>84</u> yrs
13. FATHER'S NAME <u>Reuben Horn</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Monahan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>232-24-2565</u>	
17. INFORMANT <u>Mr. William Sowers</u>		Address <u>P.O. Box 462 Glen Burnie</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPOSTATIC PNEUMONIA</u> DUE TO (b) <u>ACUTE PYELONEPHRITIS w/ ABSCESS FORMATION</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INANITION ; CHRONIC BRAIN SYNDROME</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>67</u> , to <u>9/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9-15</u> , 19 <u>67</u> , and that death occurred at <u>6:55</u> M., from causes and on the date stated above			
22a. SIGNATURE <u>M. G. Lakshman Rao</u>		22b. DATE SIGNED <u>Sept 16, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>M. G. LAKSHMAN RAO</u>		22d. ADDRESS <u>CROWNSVILLE STATE HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Trissets Cen</u>	23d. LOCATION (City or Town) (County) (State) <u>Broadway Va.</u>
24. FUNERAL DIRECTOR <u>McGully, inf 237</u>		25a. REC'D BY REGISTRAR <u>SEP 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11876

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

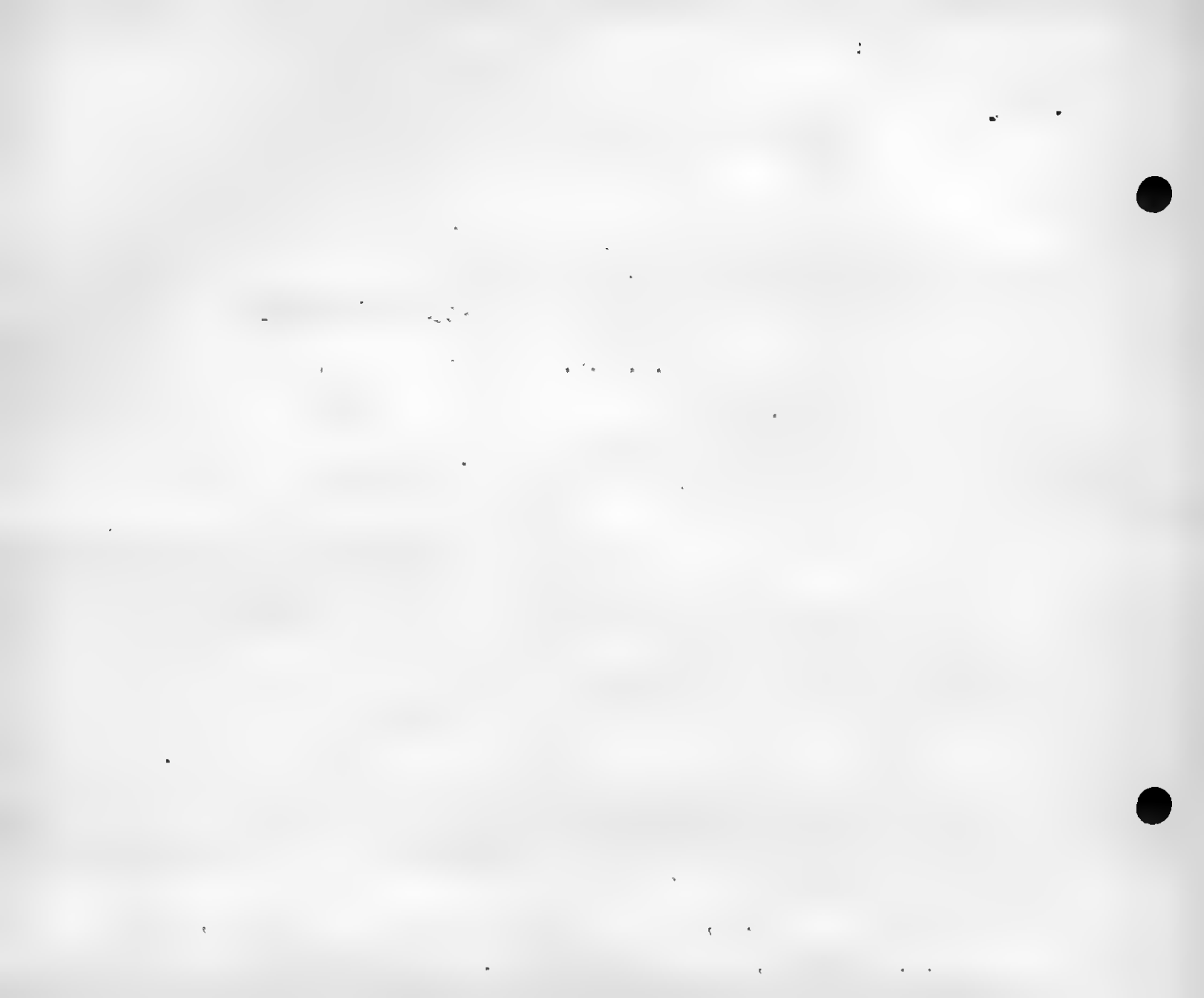
11890

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Texas</u> b. COUNTY <u>Dallas</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c LENGTH OF STAY IN Id	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>		e STREET ADDRESS <u>4821 Sandrelynn Dr</u>	
3 NAME OF DECEASED (Type or print) <u>Barney. T. Long</u>		4 DATE OF DEATH Month <u>9</u> Day <u>1</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 CO. OR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 AGE (In years last birthday) <u>24 1/2</u> yrs
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.T.&S.F.</u>	
11. BIRTHPLACE (State or foreign country) <u>Big Springs, Texas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George W. Long</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Abney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>525/05/4299</u>	
17. INFORMANT <u>Mrs. Ethelee Long</u>		Address <u>Same As # 2</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Thrombosis</u> DUE TO (b) <u>Sudden</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>No injury</u>	
20c. TIME OF INJURY Month Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form factory, prison, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspect an <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Charles H. Wirth M.D.</u>		22. DATE SIGNED <u>9/1/67</u>	
EXAMINER'S NAME (Type) <u>Charles H. Wirth M.D.</u>		Address (Street city town or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 6, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Edgewood Cemetery</u>	
23d. LOCAL (City or town) (County) (State) <u>Edgewood, Texas</u>		23e. REC'D BY REG STRAR <u>Charles Judge</u>	
24. FUNERAL DIRECTOR <u>R.V. SINGLETON,</u>		25b. REG STRAR'S SIGNATURE <u>GLEN BURNIE, MD.</u>	
DATE <u>SEP 5 1967</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 7/61
A348
10/18/67

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11877
CERTIFICATE OF DEATH
11891

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis c. LENGTH OF STAY IN TB life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1125 Eastport Terrace				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 1125 Eastport Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) ANTONETTE YVONNE LOWE		4. DATE OF DEATH Sept. 15 19 67		5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 25, 1936		9. AGE (In years, months, days) 31 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY *****				11. BIRTHPLACE (Country & State, or foreign country) Annapolis, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Charles Lowe				14. MOTHER'S MAIDEN NAME Ethel Strickney				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 214-56-0299		17. INFORMANT Hattie Forrester - 1125 Eastport Terrace Address Annapolis, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Palsy - Pneumonia 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 wks												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____									
21. I certify that (I) (this hospital) attended the deceased from 8-7-67 19____, to 9-15-67 19____, that (I) (we) last saw the deceased alive on 9-14-67 19____, and that death occurred at 5 AM , from the causes and on the date stated above.															
22a. SIGNATURE A.T. Allen				22b. DATE SIGNED 9-15-67				22c. PHYSICIAN'S NAME (Type) A.T. ALLEN				22d. ADDRESS Cathedral Street Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept. 18-67		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill				23d. LOCATION (City, town or county) Annapolis, Md. (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE C.E. Hicks				ADDRESS 111 Annapolis, Md.				25a. REC'D BY REGISTRAR SEP 22 1967		25b. REGISTRAR'S SIGNATURE [Signature]					

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

<div> <div>11878</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT</div> </div> </div> <div> <div>11878</div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT</div> </div> </div>												
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Annapolis c. LENGTH OF STAY IN TB D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital (Dead on arrival)					2. USUAL RESIDENCE (Where deceased lived, if institution Res. before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis d. STREET ADDRESS 518 First St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Peter Harold MAYHEW			4. DATE OF DEATH Month September Day 1 Year 1967		5. SEX Male			6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH April 12, 1941			9. AGE (In years last birthday) 26 yrs <div> IF UNDER 1 YEAR Months 0 Days 0 </div>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Maintenance - State		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John M. Mayhew, Sr.					14. MOTHER'S MAIDEN NAME Mary C. Come							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			16. SOCIAL SECURITY NO 216-36-7100		17. INFORMANT Mrs. Betty Mayhew - same as #2 above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed Skull DUE TO (b) Fracture left thigh (Immediate) DUE TO (c) Fracture Rt femur (and tons, if any, which gave rise to immediate cause (a), stating the underlying cause last.)										INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Car in which he was driven hit a tree stump.								
20c. TIME OF INJURY Month, Day, Year 2:25 PM 9/1 1967				20d. INJURY OCCURRED While <input type="checkbox"/> at work or Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street office bldg, etc.) Highway		20f. (City or town) Anne Arundel (County) Md. (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Albert L. Anderson, M.D.						22. DATE SIGNED 9/1/67 44 Southgate Ave., Annapolis, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Sept. 4, 1967		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) Annapolis (County) A.A. (State) Md.				
24. FUNERAL DIRECTOR Shopping Funeral Home - Annapolis, Md.						25a. REC'D BY REG. STR. SEP 6 1967		25b. REG. STR.'S SIGNATURE [Signature]				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11873
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>AA Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> b. COUNTY <u>Camden</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Crowsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Haddonfield</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. 1 - Box 70</u>		d. STREET ADDRESS <u>110 Hutchinson Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Ivin Johnston Matlack</u>		4. DATE OF DEATH <u>9-19-67</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 12, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Former</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Former</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WATSON MATLACK</u>		14. MOTHER'S MAIDEN NAME <u>MARY WALKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-266146</u>	
17. INFORMANT <u>William E. Matlack - Crowsville, Md</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Tavi DUE TO (b) <u>E.C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> 19 to <u>1967</u> 19, that (I) (we) last saw the deceased alive on <u>9-19-67</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u>		22b. DATE SIGNED <u>9-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		22d. ADDRESS <u>P.O. Box 73 Severna Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/23/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Camden, Co. New Jersey</u>
24. FUNERAL DIRECTOR <u>Robert Pulina</u>		25a. REC'D BY REGISTRAR <u>SEP 21 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Johnnie Judge</u>			

11893

11880

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 4 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 25 W. Washington St.,	
3 NAME OF DECEASED (Type or print) Tammy Tashew Matthew		4 DATE OF DEATH Month September Day 30 Year 19 67	
5 SEX Female	6 COLOR OR RACE Negro	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 30, 1967
9 AGE (in years lost birthday) 4 yrs		10 IF UNDER 1 YEAR Months 4 Days 00	
11a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		11b KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel, Maryland		12 CITIZEN OF WHAT COUNTRY? U.S.	
13 FATHER'S NAME Ormond Matthew		14 MOTHER'S MAIDEN NAME Betty Ann Coates	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.	
17 INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY 7625 IMMEDIATE CAUSE (a) Respiratory Failure - Atelectasis DUE TO (b) Immaturity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Immature birth	
20c TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (do not) attended the deceased from Sept. 30, 1967 , to Sept. 30 1967 , that (I) (not) saw the deceased give an Sept. 30 1967 , and that death occurred at 4:45 PM from causes and on the date stated above.			
22a SIGNATURE Jonathan McC. Sutton, M.D.		22b DATE SIGNED 10/3/67	
22c PHYSICIAN'S NAME (Type) Jonathan McC. Sutton, M.D.		22d ADDRESS 201 Forbes St., Annapolis, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF 10-4-67	23c NAME OF CEMETERY OR CREMATORY Pine Lawn Cemetery	23d LOCATION (City or town) (County) (State) Annapolis Md.
24 FUNERAL DIRECTOR William Beesett	25a REC'D BY REGISTRAR Anna M.D.		25b REGISTRAR'S SIGNATURE William Beesett
25c DATE OCT 3 1967		25d	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

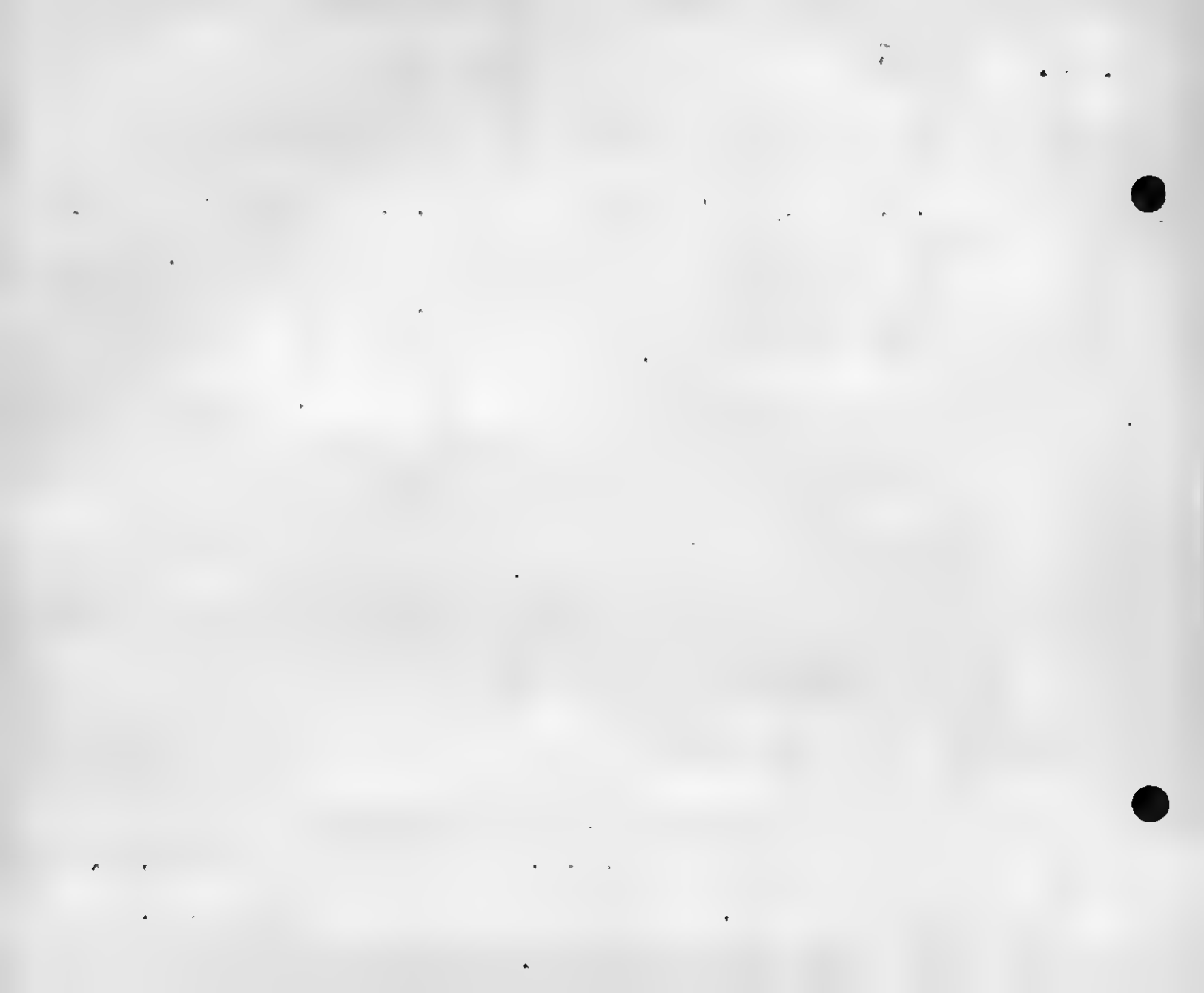
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11881

CERTIFICATE OF DEATH

11896

1. PLACE OF DEATH a. COUNTY <u>Anno Arundel</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> c. LENGTH OF STAY IN 1b <u>Pasadena</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rte. 7, Box 328, Grey's Creek Road</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u> d. STREET ADDRESS <u>Rte. 7, Box 328, Grey's Creek Road</u> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle <u>L.</u> Last <u>Melvin</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5 Sept. 1889</u>	9. AGE (In years last birthday) <u>78</u> yrs.	10. UNDER 1 YEAR Months <u>7</u> Days <u>14</u> Hours <u>15</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-Employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ret.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>	
13. FATHER'S NAME <u>John Melvin</u>		14. MOTHER'S MAIDEN NAME <u>Unk.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 1</u>		17. INFORMANT <u>Eleanora Melvin, same as 2</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary arteriosclerotic heart disease</u> DUE TO (c) <u>Cardiac decompensation</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>19</u>		20g. (County) <u>19</u>		20h. (State) <u>19</u>	
21. I certify that (I) (the hospital) attended the deceased from <u>5/24</u> , 19 <u>63</u> , to <u>9/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/19</u> , 19 <u>67</u> , and that death occurred at <u>4P</u> M, from the causes and on the date stated above.					
22a. SIGNATURE <u>R. M. McLaughlin</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Randall McLaughlin, M. D.</u>		22d. ADDRESS <u>3708 Mountain Road, Pasadena, Md.</u>			
22b. DATE SIGNED <u>9/20/67</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>25 Sept. 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
23d. LOCATION (City, town or county) <u>Baltimore, Md.</u>		(State)			
24. FUNERAL DIRECTOR <u>Kirkley Funeral Home, Glen Burnie, Md.</u>		25a. REC'D BY REGISTRAR <u>SEP 25 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>J. J. Jones</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11897

11882

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b 1 day		Ellicott City 13	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d. STREET ADDRESS 17 Amherst Ave	
3. NAME OF DECEASED (Type or print) Robert Stanford Newsome		4. DATE OF DEATH September 13 1967	
5 SEX Male	6 COLOR OR RACE Cauc	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8 DATE OF BIRTH April 15, 1920
9 AGE (In years lost birthday) 47 yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	10b. KIND OF BUSINESS OR INDUSTRY W R Grace Co	11. BIRTHPLACE (County & State, or foreign country) Ahoskie, N.C.
12 CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Hoard Newsome		
14. MOTHER'S MAIDEN NAME Bruce Estelle		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1937-1957	
16. SOCIAL SECURITY NO 565-48-1970		17. INFORMANT Mrs Robert Newsome Address 17 Amherst Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Cardiac Arrest			
DUE TO (b) Acute Myocardial Infarction			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 13 SEP , 19 67 , to 13 SEP , 19 67 , that (I) (we) last saw the deceased alive on 13 SEP , 19 67 , and that death occurred at 9:20 PM , from causes on and on the date stated above.			
22a. SIGNATURE <i>Stanley L. Kampner</i> M.D.		22b. DATE SIGNED 13 Sep 67	
22c. PHYSICIAN'S NAME (Type) STANLEY L. KAMPNER, CPT, MC		22d. ADDRESS KIMBROUGH ARMY HOSPITAL FT MEADE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Sept. 17 '67	23c. NAME OF CEMETERY OR CREMATORY Crest Lawn	23d. LOCATION (City or Town) (County) (State) Marriottsville Howard Co.
24. FUNERAL DIRECTOR Howard County Funeral Home		25a. RECD BY REGISTRAR SEP 18 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

VR A15 (4)
20M 1/65

5-7/14.
D. Frank.
after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

11882

71898

1. PLACE OF DEATH a. COUNTY A A Co		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY A A Co	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millersville		c. LENGTH OF STAY IN 1b Arundel Gardens	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Knollwood Manor Nursing Home		d. STREET ADDRESS 418 Creswell Rd	
3. NAME OF DECEASED (Type or print) Walter T Owen		4. DATE OF DEATH Month Sept Day 13 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 22, 1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Building	11. BIRTHPLACE (County & State, or foreign country) Va
13. FATHER'S NAME William Henry Owen		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 223-18-7398	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure 241X } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute pulmonary edema DUE TO (c) Chronic asthma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Emphysema, chronic angustine heart failure INTERVAL BETWEEN ONSET AND DEATH 1 day 1 day			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/19, 1967 to 9/13, 1967 that (I) (we) last saw the deceased alive on 9/13, 1967 and that death occurred at 6:20 PM from the causes and on the date stated above.			
22a. SIGNATURE Max C Frank MD		22b. DATE SIGNED 9/14/67	
22c. PHYSICIAN'S NAME (Type) MAX C FRANK MD		22d. ADDRESS 425 SE Nichols Hwy Glen Burnie Md 21061	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9/16/67	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem	23d. LOCATION (City, town or county) (State) Glen Burnie Md
24. FUNERAL DIRECTOR Mc Culley F.H. 737 Latapana ave 21225		25a. REC'D BY REGISTRAR SEP 18 1967	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11884

CERTIFICATE OF DEATH

11899

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 8 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1122 Myrtle Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernice Palmer		4. DATE OF DEATH Month 9 Day 8 Year 1967	
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/21/22
9. AGE (In years lost birthday) 45 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician	11. BIRTHPLACE (County & State or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles Palmer	
14. MOTHER'S MAIDEN NAME Theresa Hall		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown	
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Records, Crownsville, Maryland	
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART I. DEATH WAS UNDERLYING 583X IMMEDIATE CAUSE (a) Hepatic failure DUE TO Chirrhosis of liver or Generalized Carcinomatosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Anemia Severe		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/31/1967 , to 9/8/1967 , that (I) (we) last saw the deceased alive on 9/8/1967 and that death occurred at 7:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE Lionel McHenry Mapp, M.D.		22b. DATE SIGNED 9/8/67	
22c. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D.		22d. ADDRESS Crownsville State Hospital, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-12-67	23c. NAME OF CEMETERY OR CREMATORY Northwood	23d. LOCATION (City or Town) (County) (State) Baltimore
24. FUNERAL DIRECTOR Marshall H. Hays		25a. REC'D BY REGISTRAR SEP 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

701

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11885

CERTIFICATE OF DEATH

11900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital, Annapolis, Md.				d. STREET ADDRESS 5A Carver St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RUDOLPH WILLIAMS PARKER				4. DATE OF DEATH Month Day Year September 28 19 67			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7, 1904		9. AGE (In years, months, days) 63 yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SD2		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Ret		11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Alonso Williams				14. MOTHER'S MAIDEN NAME Sarah Parker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO 213-34-4160		17. INFORMANT Annapolis, Md. Minnie Parker 5A Carver St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMPHYSEMA 537.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Cor pulmonale						INTERVAL BETWEEN ONSET AND DEATH 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 18 Sept. , 19 67 , to 28 Sept. , 19 67 , that (I) (we) just saw the deceased alive on 28 Sept. , 19 67 , and that death occurred at 1355 M, from causes and on the date stated above.							
22a. SIGNATURE M. F. FORDNES, LCDR MC USN				ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22b. DATE SIGNED 9-28-67	
22c. PHYSICIAN'S NAME (Type) M. F. FORDNES, LCDR MC USN				22d. ADDRESS NAVAL HOSPITAL, ANNAPOLIS, MD.			
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		Oct. 3-67		St. Marys		Annapolis, Maryland	
24. FUNERAL DIRECTOR Charles E. Hicks III Annapolis, Md.				25a. REC'D BY REGISTRAR OCT 4 1967		25b. REGISTRAR'S SIGNATURE Charles J. ...	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11901

11886

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>NAPO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA - PARK</u>		c. LENGTH OF STAY IN MD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SEVERNA - PARK, MD</u>		d. STREET ADDRESS <u>RLI - Box 518</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DCA - NORTH MEUNDEL-Hop</u>				e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CLARA FLORENCE PATTERSON</u>				4. DATE OF DEATH Month <u>9</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>63</u> Yes		9. AGE (In years past birthday) <u>63</u> Yes		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STENOGRAPHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ROBERT HOEL</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH THUMBORG, Vt.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Ada H. H. H. H.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-22-7363</u>		17. INFORMANT <u>FRED PATTERSON</u>		Address <u>SEVERNA Pt. MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> DUE TO (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. L. H. H. H.</u>		EXAMINER'S NAME (Type) <u>E. L. H. H. H.</u>		22. DATE SIGNED <u>9-4-67</u>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>9-7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, A.A. Co., MD</u>	
24. FUNERAL DIRECTOR <u>Manfred P. Hays</u>				ADDRESS <u>638 N. G. L. H. H. H.</u>		25a. REC'D BY REGISTRAR <u>SEP 7 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

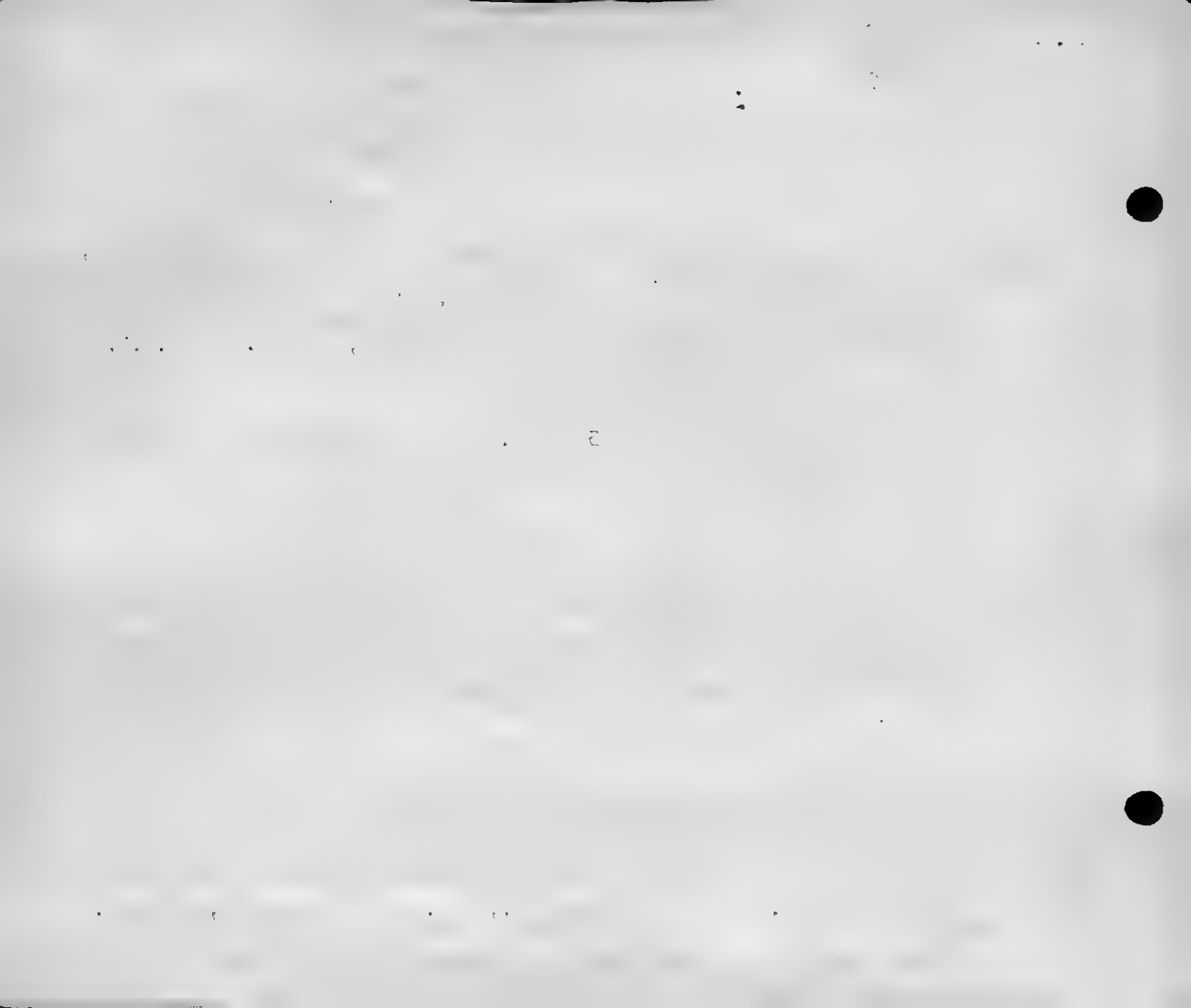
1

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

11887

11902

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ANNE Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie d. STREET ADDRESS #1307 Meadowvale			
3. NAME OF DECEASED (Type or print) CHARLOTTE First Middle Last PEACOCK				4. DATE OF DEATH Month Day Year September 13, 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 11, 1909	
9. AGE (In years last birthday) yrs. 58		10. IF UNDER 1 YEAR Months Days 58		11. IF UNDER 24 HRS. Hours Min. 58			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician				10b. KIND OF BUSINESS OR INDUSTRY Self-Employed		11. BIRTHPLACE (Country & State, or foreign country) Pittsburgh, Pennsy.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Harry Lever				14. MOTHER'S MAIDEN NAME (unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no				16. SOCIAL SECURITY NO. 201 14 5561		17. INFORMANT Address Mr. Glen Peacock (husband) Same As #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour e.m. 11:30 p.m. 9 13 19 67 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) Salisbury, Md. 1967 to Sept. 13, 1967 , that (I) (we) last saw the deceased alive on 9-13-1967 , and that death occurred at 11:30 p.m. from the causes and on the date stated above.							
21. I certify that (I) (this hospital) attended the deceased from Salisbury, Md. 1967 , to Sept. 13, 1967 , that (I) (we) last saw the deceased alive on 9-13-1967 , and that death occurred at 11:30 p.m. from the causes and on the date stated above.							
22a. SIGNATURE Wayne B Tate, M.D. 22b. DATE SIGNED SEP 18 1967 22c. PHYSICIAN'S NAME (Type) WAYNE B TATE, M.D. 22d. ADDRESS 108 CENTRAL AVE GLEN BURNIE							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Sept. 18/67 23c. NAME OF CEMETERY OR CREMATORY Allegheny Co., Mem. Park Pittsburgh, Pennsy. 23d. LOCATION (City, town or county) (State) Glen Burnie, Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Charles Judge 25a. REC'D BY REGISTRAR SEP 18 1967 25b. REGISTRAR'S SIGNATURE Charles Judge							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

11888

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11903

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN Tb 11 hours		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Pasadena	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS Rt-2, Box-193		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rena Dolores PERRY		4. DATE OF DEATH Month September Day 13 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1887		9. AGE (In years last birthday) 80 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milliner (ret.)		10b. KIND OF BUSINESS OR INDUSTRY Fashion Millinery		11. BIRTHPLACE (County & State or foreign country) Massachusetts	
13. FATHER'S NAME Erving A. Roe		14. MOTHER'S MAIDEN NAME Rena Swist		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217 14 6310A		17. INFORMANT Mrs. Ruth E. Eckert (daughter) same as #2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 170X IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO (b) Primary Carcinoma Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)				INTERVAL BETWEEN ONSET AND DEATH 4 mo. 2 YRS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour pm 19 62		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
21. I certify that (I) (the doctor) attended the deceased from Sept. 13 1967 to Sept. 13 1967 , that (I) (the doctor) saw the deceased alive on Sept. 13 1967 , and that death occurred at 7:15 AM from causes and on the date stated above		22b. DATE SIGNED Sept. 13 1967			
22a. SIGNATURE Arthur Lankford Jr. M.D.		22c. PHYSICIAN'S NAME (Type) Arthur Lankford, Jr.		22d. ADDRESS 2934 Mountain Road, Pasadena, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION (City or Town) Baltimore, Maryland		23e. ADDRESS Singleton Funeral Home		23f. DATE SEP 18 1967	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
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VR A15 (4)
25M 1/67

11889		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
CERTIFICATE OF DEATH			
1904			
1 PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>D.C.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deale</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deale</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Drum Point Road</i>		d. STREET ADDRESS <i>Deale Beach</i>	
3. NAME OF DECEASED (Type or print) <i>CLARENCE VINSON Phipps</i>		4. DATE OF DEATH <i>Sept. 6 1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>July 23, 1918</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SUPERVISOR</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BOAT YARD</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Deale, Md</i>
13. FATHER'S NAME <i>GUY Phipps</i>		14. MOTHER'S MAIDEN NAME <i>CLORA ROGERS</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO <i>217 16 7249</i>	
17. INFORMANT <i>BERTHA ANDERSON, Deale, Md</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrhythmia - ventricular fibrillation</i>		INTERVAL BETWEEN ONSET AND DEATH <i>9 months</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		(b) <i>Arteriosclerotic heart disease and</i>	
(c) <i>previous myocardial infarction</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Nov. 66</i> to <i>Sept 6 1967</i> , that (I) (we) last saw the deceased alive on <i>Sept. 6 1967</i> , and that death occurred at <i>1:30 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Willard F. Smith</i>		22b. DATE SIGNED <i>9/7/67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Willard F. Smith MD</i>		22d. ADDRESS <i>Shady Side, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>9-9-67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>MT Zion</i>	23d. LOCATION (City or Town) (County) (State) <i>Lothian, Md, MCO</i>
24. FUNERAL DIRECTOR <i>Harshbarger Funeral Home, Galesville, Md</i>		25a. REC'D BY REGISTRAR <i>SEP 14 1967</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

CERTIFICATE OF DEATH

11890

11905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. LENGTH OF STAY IN 1b <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>736 Patterson Park</u>			
3. NAME OF DECEASED (Type or print) <u>(Sophie) Sophia M. Popiolek</u>				4. DATE OF DEATH Month <u>9</u> Day <u>29</u> Year <u>1967</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/4/92</u>	
9. AGE (In years lost birthday) <u>75</u> yrs		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS Hours <u>—</u> Min <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Domestic work</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Smith</u>				14. MOTHER'S MAIDEN NAME <u>Rosie Ann x Chew</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-14-9978</u>		17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Fluid and Electrolyte Imbalance</u>							
DUE TO <u>Intestinal obstruction</u>							
DUE TO (b) <u>—</u>							
DUE TO (c) <u>—</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<u>Chronic Brain Syndrome due to Cerebral arteriosclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/7/1965</u> to <u>9/29/1967</u> , that (I) (we) last saw the deceased alive on <u>9/29/1967</u> , and that death occurred at <u>1:30 P.M.</u> from causes and on the date stated above							
22a. SIGNATURE <u>L. Benedict, M.D.</u>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>9/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>				22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/2/67.</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>				25a. REC'D BY REGISTRAR <u>OCT 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #4 Film #G392 9/13/67 ph

11891

CERTIFICATE OF DEATH

11906

1. PLACE OF DEATH a. COUNTY Anne Arundel County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Annapolis Nursing & Convalescent Center				d. STREET ADDRESS 6 Bristol Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Fannie May Potter				4. DATE OF DEATH Month Day Year Sept. 12 19 67			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-7-1883	
9. AGE (In years last birthday) 87 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME		11. BIRTHPLACE (County & State, or foreign country) PRINCESS ANNE CO. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME CALEB BEACHAW				14. MOTHER'S MAIDEN NAME NANCY HARRISON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT E. B. POTTER #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure DUE TO (b) Hypertension DUE TO (c) Debridement Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost							INTERVAL BETWEEN ONSET AND DEATH undetermined
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1960 to 9-12 1967, that (I) (we) last saw the deceased alive on Sept 10 1967, and that death occurred at 4:00 M, from causes and on the date stated above							
22a. SIGNATURE W. P. STEPHENS				22b. DATE SIGNED 12 Sept 1967		22c. PHYSICIAN'S NAME (Type) W. P. STEPHENS	
23a. BURIAL CREMATION - REMOVAL (Specify) Burial				23b. DATE THEREOF 9-13-67		23c. NAME OF CEMETERY OR CREMATORY St. Anne's	
24. FUNERAL DIRECTOR John M. Joynt Sons Annapolis, Md.				25a. REC'D BY REGISTRAR SEP 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
23d. LOCATION (City or town) (County) (State) Annapolis MD.				23e. ADDRESS Annapolis, Md.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
11892		CERTIFICATE OF DEATH	
11907			
1. PLACE OF DEATH a. COUNTY <u>Ann Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>4 1/2 Months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Annapolis Nursing Home</u>		e. STREET ADDRESS <u>5035-36th Street North</u>	
3. NAME OF DECEASED (Type or print) <u>Valentine</u>		4. DATE OF DEATH <u>Sept 8, 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/14/84</u>
9. AGE (In years, last birthday) <u>83</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shoe Buyer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Richter</u>		14. MOTHER'S MAIDEN NAME <u>Frederika Strauss</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>3035 N. 36th St</u>	
17. INFORMANT <u>Mrs. William H. Adrian</u>		Address <u>Arlington, Va.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>4200 Arteriosclerotic heart disease</u> DUE TO (b) <u>Complete heart block</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>61</u> , to <u>Sept 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Aug 9, 1967</u> , and that death occurred at <u>11:00 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Willard F. Smith</u> M.D.		22b. DATE SIGNED <u>9/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard F. Smith</u>		22d. ADDRESS <u>Shady Side, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/11/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Columbia Gardens Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>Mac H. Morris</u> <u>Arlington Funeral Home Arlington Virginia</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11893

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11908

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY N. 1b Hanover	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital		e. STREET ADDRESS Route 1 Box 7B Hanover, M.D.	
3 NAME OF DECEASED (Type or print) LENA G. ROGERS		4 DATE OF DEATH Month September Day 12 Year 1967	
5 SEX Female	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1910
9 AGE (in years lost birthday) 56 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Al Greene Ent.	
11 BIRTHPLACE (State or foreign country) West Virginia		12 CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Loughry		14. MOTHER'S MAIDEN NAME Ethel Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO 219 10 3979	
17. INFORMANT Mr. Russell R. Rogers (husband)		Address same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY 7104 IMMEDIATE CAUSE (a) Multiple Traumatic injuries DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c): stating the underlying cause lost _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) Subject's car was struck by train	
20c. TIME OF INJURY Month, Day, Year Hour 12 p.m. 9 12 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) RR Track		20f. (City or town) (County) (State) Balto. ANNE Ar. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Russell S. Fisher, M.D.		22. DATE SIGNED September 13, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 16/67	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR Singleton Funeral Home		25a. COPY REGISTERED SEP 18 1967	
25b. GLEN BURNIE, MARYLAND		25c. GLEN BURNIE, MARYLAND	

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11894

11909

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel Co</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis M.D.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River - Balt. County</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DoA ARUNDEL Gen Hspt</u>		d. STREET ADDRESS <u>324 Groveton Road</u>	
3 NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>A.</u> Last <u>Rosenbaum</u>		4 DATE OF DEATH Month <u>9</u> Day <u>2</u> Year <u>1967</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>3/20/1912</u>
9 AGE (n years last birthday) <u>55</u> yrs		10 IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Supervisor Wal-Mart Corp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Md</u>	
11 BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13 FATHER'S NAME <u>John ROSENBAUM</u>		14 MOTHER'S MAIDEN NAME <u>MINNIE FREUND</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>215-01-7810</u>	
17 INFORMANT <u>Charles A. ROSENBAUM JR</u>		Address <u>- SAME</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute dilatation of the heart</u> <u>4344</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Albert L. Andersen</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>ALBERT L. ANDERSEN</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>9/7/67</u>	
Address (Street, city, town, or county) <u>Baltimore, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/5/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oaklawn</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Md</u>
24. FUNERAL DIRECTOR <u>Joseph N. Zaccaria, Jr. 263 S. Conkling St.</u>		25a. REC'D BY REGISTRAR <u>SEP 5 1967</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



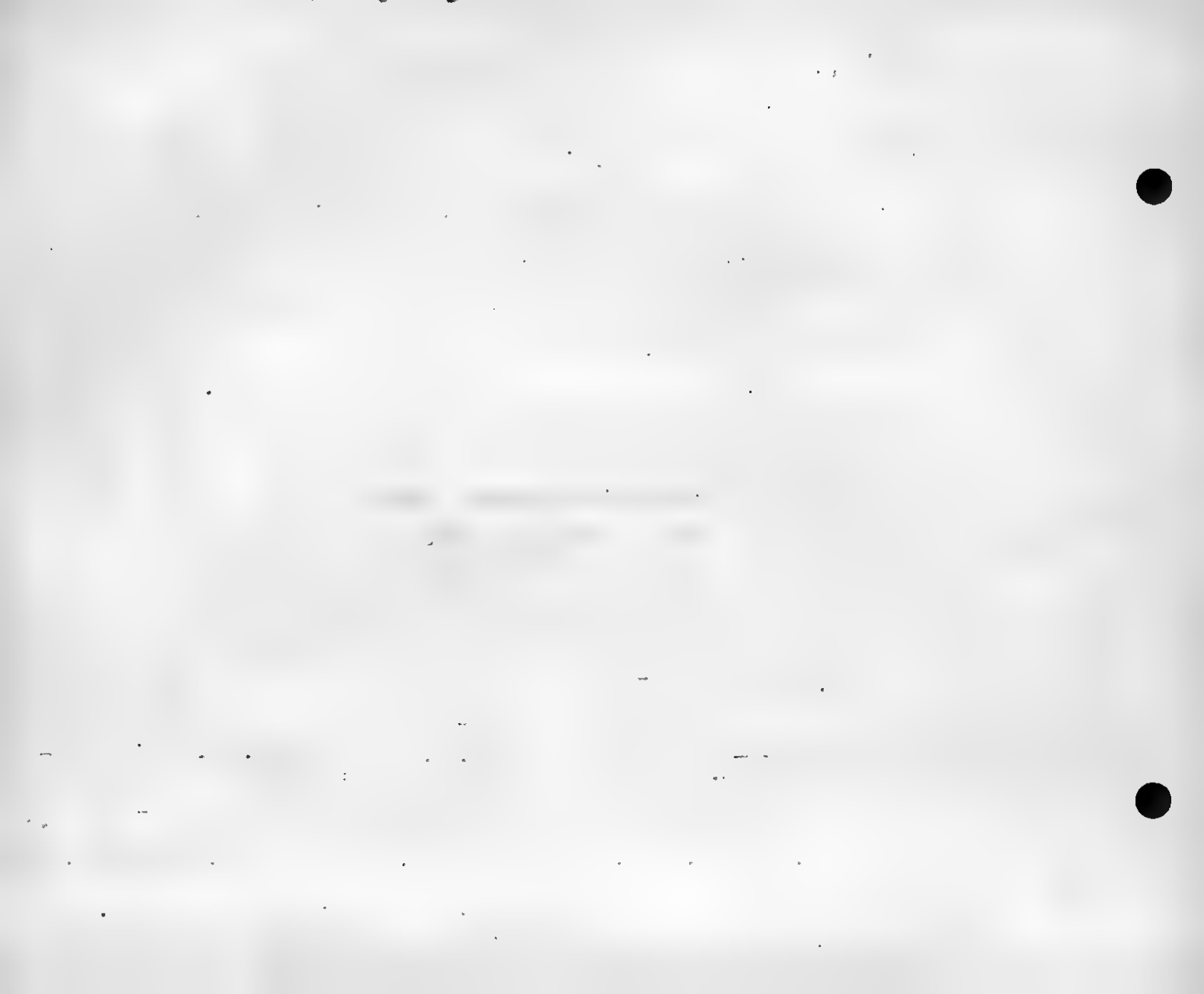
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
20M 1/63

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
11895 11910											
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie c. LENGTH OF STAY IN ID 1 month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) North Arundel Convalescent Center						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 21230 d. STREET ADDRESS 1438 Richardson St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Phillip (Philip) Rossbach						4. DATE OF DEATH Month 9 - Day 27 Year 1967					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/1884		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Russia			12. CITIZEN OF WHAT COUNTRY? Russia		
13. FATHER'S NAME Phillip Rossbach						14. MOTHER'S MAIDEN NAME Elizabeth Mildenberg					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-09-3299A		17. INFORMANT Mrs. Marie Rossbach Address 1438 Richardson St.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis (c) General arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -----											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 16.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) -----											
20c. TIME OF INJURY Month, Day, Year Hour a.m. ----- p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) ----- (County) ----- (State) -----			
21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1963 , to Sept. 27, 1967 , that (I) (we) last saw the deceased alive on Sept. 23, 1967 , and that death occurred at 10:15 PM from the causes and on the date stated above.											
22a. SIGNATURE C. C. Chiu						22b. DATE SIGNED 9-28-67					
22c. PHYSICIAN'S NAME (Type) C. C. Chiu, M. D.						22d. ADDRESS 1 E. Randall Street, Baltimore Md. 21230					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/30/67		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City, town or county) Anne Arundel, Md. (State) -----					
24. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc. ADDRESS 1501 East Fort Avenue						25a. REC'D BY REGISTRAR SEP 29 1967 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION



11896

CERTIFICATE OF DEATH

11911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN It			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital				d. STREET ADDRESS 908 Van Buren Street			
3. NAME OF DECEASED (Type or print) First Agnes Middle Estelle Last SEGELKEN				4. DATE OF DEATH Month September Day 23 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH December 15, 1896		9. AGE (In years lost birthday) yrs 70	F. UNDER 1 YEAR Months 1 Days 19 Hours 4 Min. 23	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State or foreign country) Bolton Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME J. E. MORELAND				14. MOTHER'S MAIDEN NAME CLARK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. -		17. INFORMANT HENRY F. SEGELKEN #2 Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACVD - Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost + 221 (b) Chronic pyelonephritis (c) 4 days				INTERVAL BETWEEN ONSET AND DEATH 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1963 to 9-23-67 that (I) (we) lost the deceased alive on September 23, 1967 , and that death occurred at 5:10 P.M. M, from causes and on the date stated above							
22a. SIGNATURE F. M. SHIPLEY				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9-25-67	
22c. PHYSICIAN'S NAME (Type) F. M. SHIPLEY				22d. ADDRESS Annapolis, Md.			
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-26-67		23c. NAME OF CEMETERY OR CREMATORY HILLCREST		23d. LOCATION (City or town) (County) (State) Annapolis H.A. Md.	
24. FUNERAL DIRECTOR John M. Lupton & Son				25a. REC'D BY REGISTRAR SEP 26 1967		25b. REGISTRAR'S SIGNATURE James Judge	

CERTIFICATE OF DEATH

11897

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>25 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital Drive</u>				d. STREET ADDRESS <u>405 Maple Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Theresa</u> Middle <u>C.</u> Last <u>Shute</u>				4 DATE OF DEATH Month <u>September</u> Day <u>24</u> Year <u>1967</u>			
5 SEX <u>female</u>	6 COLOR OR RACE <u>white</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-1-99</u>		9. AGE (In years last birthday) <u>67</u> yrs	10. FUNERAL 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>Lawrence Ferrari</u>				14. MOTHER'S MAIDEN NAME <u>Helen Olivito</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Unknown</u> <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>079-18-9353</u>		17. INFORMANT <u>Mr. Clarence E. Shute (husband)</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CVA</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>arteriosclerosis</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> min. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/20/67</u> , 19 <u> </u> to <u>9/24/67</u> , 19 <u> </u> , that (I) (we) lost saw the deceased alive on <u>9/23/67</u> , 19 <u> </u> , and that death occurred at <u>3:15 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>George B. Ramirez</u>				22b. DATE SIGNED <u>9/27/67</u>		22c. PHYSICIAN'S NAME (Type) <u>George Ramirez, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial Pk</u>		23d. LOCATION (City or town) (County) (State) <u>Glen Burnie, Maryland</u>	
24. FUNERAL DIRECTOR <u>S.B. Ramirez</u>				25a. REC'D BY REGISTRAR <u>SEP 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>g. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11898

CERTIFICATE OF DEATH

11813

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY 1			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millersville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 1925 Christian St.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kuollwood Manor NURSING HOME				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JULIA Middle A. Last SICKEL				4. DATE OF DEATH Month Sept Day 20 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/18/92	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 7 Days 10		11. IF UNDER 24 HRS. Hours 10 Min. 00			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY USA							
13. FATHER'S NAME Late-Henry Geldmacker				14. MOTHER'S MAIDEN NAME Late-Emma Smith			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT R. Samuel G. Sickel 1925 Christian St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Ventricular failure DUE TO (b) Septicemic shock Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Post Cerebro Vascular accident DUE TO (c) Post Cerebro Vascular accident				INTERVAL BETWEEN ONSET AND DEATH Hours Hours Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/7, 1967 to 9/20, 1967 that (I) (we) last saw the deceased alive on Sept 20, 1967 , and that death occurred at 12:30 from the causes and on the date stated above.							
22a. SIGNATURE Max C Frank				22b. DATE SIGNED 9/19/67			
22c. PHYSICIAN'S NAME (Type) MAX C FRANK				22d. ADDRESS 425 SE Ritchie Hwy - Glen Burnie			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/22/67		23c. NAME OF CEMETERY OR CREMATORY Crest Lawn Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F. D. - 4101 Edmondson Av.				25a. REC'D BY REGISTRAR DATE SEP 21 1967			
				25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

11898

11814

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>A. A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>H. H.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Marys</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bay Manor Nursing Home</u>		d. STREET ADDRESS <u>107 Tolson St.</u>	
3. NAME OF DECEASED (Type or print) <u>Alice</u> First Middle Last		4 DATE OF DEATH <u>9</u> Month <u>7</u> Day <u>19</u> Year	
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-6-1885</u> 9 AGE (In years last birthday) <u>82</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State or foreign country) <u>Chase, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Philip Bramble</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Bramble</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Grace Stallings #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arteriosclerosis</u> (c) <u>1 hour</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1 Sept</u> , 19 <u>67</u> to <u>7 Sept</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>1 Sept</u> , 19 <u>67</u> , and that death occurred at <u>5:30 AM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward S. Beck</u> M.D.		22b. DATE SIGNED <u>9/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD S. BECK</u>		22d. ADDRESS <u>FERRIS ST. ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>9-16-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>	23d. LOCATION (City or Town) (County) (State) <u>St. Marys MD</u>
24. FUNERAL DIRECTOR <u>John W. Taylor</u>		25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			

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11900

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11915

1 PLACE OF DEATH a. COUNTY <u>99</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm on) a STATE <u>MD.</u> b COUNTY <u>11</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. B.</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Batav City</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>No. An. G. H.</u>		d STREET ADDRESS <u>903 Victory Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Lawrence R. Smith</u>		4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 4 1898</u>
9. AGE (In years last birthday) <u>69</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self-employed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Christopher Columbus</u>		14. MOTHER'S MAIDEN NAME <u>Mary Mullinix</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give word dates of service) <u>Yes</u> <u>WWF</u>		16. SOCIAL SECURITY NO. <u>217-03-1768</u>	
17. INFORMANT <u>Mrs. Emma R. Smith</u>		Address <u></u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic heart disease</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a m.</u> p m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the doctor) attended the deceased from <u>12/16/66</u> , 19 <u>66</u> , to <u>8/9/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/9/67</u> , 19 <u>67</u> , and that death occurred at <u></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Samuel Rubin</u> M.D.		22b. DATE SIGNED <u>9/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Samuel Rubin, M.D.</u>		22d. ADDRESS <u>203 E. Patapsco Avenue Baltimore, Md. 21225</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>9-11-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Baltic Hill</u>	23d. LOCATION (City or town) (County) (State) <u>Balto Md.</u>
24. FUNERAL DIRECTOR <u>Loung Byars</u>		25. REC'D BY REGISTRAR <u>Randall</u> DATE <u>SEP 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11901

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie -</u>	
c. LENGTH OF STAY IN 1b <u>4yrs.</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		a. STREET ADDRESS <u>2700 Felter Lane</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Lula V. Smith</u>		4. DATE OF DEATH Month Day Year <u>Sept. 14 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/82</u>
9. AGE (In years last birthday) <u>84 yrs</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (Country, & State, or foreign country) <u>Loudon Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alphus Poland</u>		14. MOTHER'S MAIDEN NAME <u>Label L. Rice</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>213-56-1886</u>	
17. INFORMANT <u>Margaret Waataja</u>		Address <u>Bowie, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO <u>Coronary Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Sclerotic Cordis Usual Old</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>9/14/67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1965</u> , 19 <u>65</u> , to <u>8/14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/14</u> , 19 <u>67</u> , and that death occurred at <u>3:4</u> -M, from causes and on the date stated above			
22a. SIGNATURE <u>Felix P. Jones</u>		22b. DATE SIGNED <u>9/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Felix P. Jones</u>		22d. ADDRESS <u>1130 Decker Rd. Odessa, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 16-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Simon Bros.</u>		ADDRESS <u>1100 S. Bros. - 1100 Good Hope Rd SE Wash DC</u>	
25a. REC'D BY REGISTRAR DATE <u>SEP 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
11902									
11917									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY AA				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			c. LENGTH OF STAY IN 1b 14 minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel					d. STREET ADDRESS 105 Dorchester Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Howard Clarence Snider					4. DATE OF DEATH Month Day Year Sept. 1, 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9 June 1905		9. AGE (In years last birthday) 62 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY B. & O. RR		11. BIRTHPLACE (County & State, or foreign country) Fairmont, W. Virginia			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs. Mabel Snider, Same as 2 Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 40 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO (c) <u>angina</u>								INTERVAL BETWEEN ONSET AND DEATH 1 minute 3 months " "	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mel.</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/12/67</u> , 19 <u>67</u> , to <u>9/1/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>9/1/67</u> , 19 <u>67</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>David Abramson</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) David L. Abramson, M.D.					22d. ADDRESS Glen Burnie, Md. 707 Old Annapolis Road N.E.,				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5 Sept. 1967		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		23d. LOCATION (City, town or county) (State) Elkridge, Maryland			
24. FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md.					25a. REC'D BY REGISTRAR DATE SEP 6 1967		25b. REGISTRAR'S SIGNATURE <u>James J. Age</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 14 File #0322 9/20/67 ph

CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) ✓ a. STATE Maryland b. COUNTY Baltimore Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 12 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		e. STREET ADDRESS 200 Birdwood Ave.,	
3 NAME OF DECEASED (Type or print) First Middle Last Thomas Berville SNYDER		4 DATE OF DEATH Month Day Year September 9 19 67	
5 SEX Male	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 8 Aug. 17, 1910
9. AGE (In years last birthday) 57 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer	
10b. KIND OF BUSINESS OR INDUSTRY Koppers Company		11 BIRTHPLACE (County & State, or foreign country) Hampstead, Maryland	
12 CITIZEN OF WHAT COUNTRY? U.S.		13 FATHER'S NAME Thomas F. Snyder	
14 MOTHER'S M maiden name Lotta B. Frankforter Lotta B. Frankforter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16 SOCIAL SECURITY NO 212-09-8866		17 INFORMANT Esther M. Snyder, same as 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY 3.31x IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) 14 hours DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 14 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that (I) deceased attended the deceased from Sept. 9 , 19 67 , to Sept. 9 , 19 67 that (I) was saw the deceased alive on Sept. 9 , 19 67 , and that death occurred at 11:05 PM M, from causes on the date stated above.		22a SIGNATURE Richard I. Hochman M.D. ATTENDING PHYS. XXX MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c PHYSICIAN'S NAME (Type) Richard I. Hochman, M.D.		22d ADDRESS 16 Murray Ave., Annapolis, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE THEREOF 13 Sept. 67	
23c NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		23d LOCATION (City or Town) (County) (State) Glen Burnie, Maryland	
24 FUNERAL DIRECTOR Kirkley Funeral Home, Glen Burnie, Md. 21061		25a REC'D BY REGISTRAR SEP 14 1967	
25b REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

11904

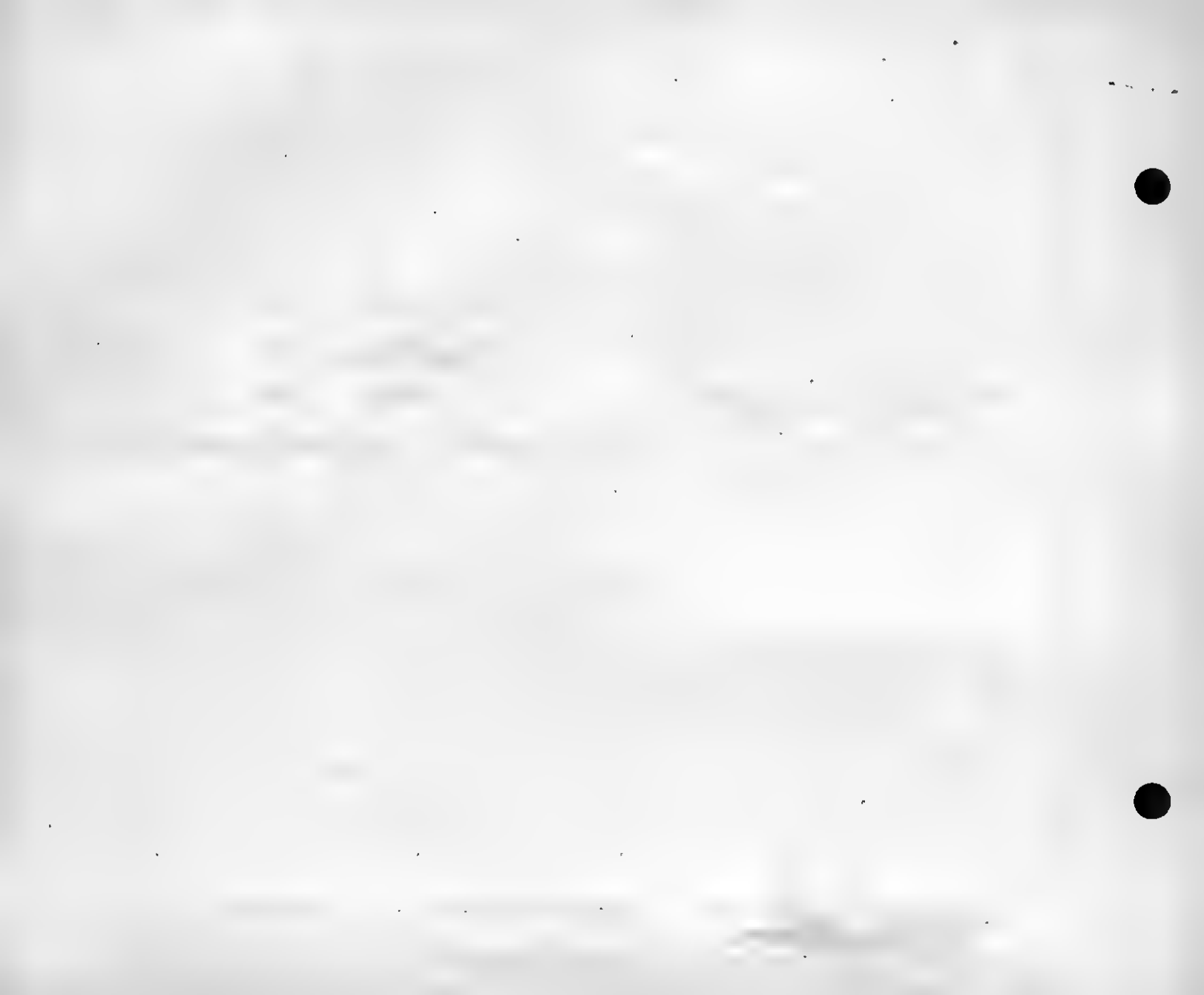
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

17519

1. PLACE OF DEATH a. COUNTY <u>A.A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>1st</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lexington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Laurel Hospital</u>		d. STREET ADDRESS <u>Cypress Cr. Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>Steins Dorfer</u> Last <u>Fer</u>		4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4 Aug. 1905</u>
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>2</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Engelke</u>		14. MOTHER'S MAIDEN NAME <u>Estella Darr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-07-8735</u>	
17. INFORMANT <u>John T. Hagedorn (husband)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 7144 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Myocardial Infarction + Myocardial Disease</u> DUE TO (c) <u>Rheumatic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>9-3-67</u> , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>11:45</u> AM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert R. Hahn</u> M.D.		22b. DATE SIGNED <u>9-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert R. HAHN</u>		22d. ADDRESS <u>Severna Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Woodlawn Md.</u>	
24. FUNERAL DIRECTOR <u>James J. Smith</u>		25a. REC'D BY REGISTRAR <u>SEP 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>James J. Smith</u>			



11905

CERTIFICATE OF DEATH

11920

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gen Burnie</u>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gen Burnie</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Arundel Convalescent Center</u>			d. STREET ADDRESS <u>1424 OAKDALE RD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Lucy</u>		First Middle Last <u>STRAUSER</u>		4. DATE OF DEATH Month <u>9</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-15</u>		9. AGE (In years last birthday) <u>51</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cashier</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Parking Garage</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Houston Texas</u>	
13. FATHER'S NAME <u>Judson Knight</u>		14. MOTHER'S MAIDEN NAME <u>Della (Unknown)</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>212-22-3431</u>		17. INFORMANT <u>Mr. Raymond E. Strauser (Husband)</u> Address <u>Someplace</u>	
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conception, Heart Failure</u> DUE TO (b) <u>Genitally transmitted carcinoma</u> DUE TO (c) <u>Carcinoma of breast</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/11</u> , 19 <u>67</u> to <u>9/20</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>9/20</u> , 19 <u>67</u> , and that death occurred at <u>12:34 A.M.</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>William L. Livsao</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/21/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Livsao</u>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMAIN (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Sept. 24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Tuscola Cemetery</u>	23d. LOCATION (City or town) <u>Tuscola, Illinois</u> (County) (State)		
24. FUNERAL DIRECTOR <u>R. K. Singleton</u>		ADDRESS <u>Singleton Funeral Home</u> <u>6400 Burnie, Md.</u>		25. RECD BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

CERTIFICATE OF DEATH

11905

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup c. LENGTH OF STAY IN b 21 Months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Maryland House of Correction		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 251 South Broadway Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Substanley		4. DATE OF DEATH Month Day Year September 10 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-1912
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Philippi, W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph (deceased)		14. MOTHER'S MAIDEN NAME Catherine nee Kordea (deceased)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Denied		16. SOCIAL SECURITY NO. 213-07-5856	
17. INFORMANT Institutional Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 7.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 19....., to 19....., that (I) (we) last saw the deceased alive on 9-10-1967, and that death occurred at 10:20 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Rolando V. Goco, M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Rolando V. Goco, M.D.		22d. ADDRESS 8th and Gorman Sts., Laurel, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9-14-67	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE Walter Dabrowski		25. REC'D BY REGISTRAR DATE SEP 15 1967	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

13363

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>removal</i>	23b. DATE THEREOF <i>OCT 6, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>UNIVERSITY OF MD</i>	23d. LOCATION (City or Town) (County) (State) <i>BALTIMORE MD</i>
24. FUNERAL DIRECTOR <i>WM REESE JR 1014 N. WASHINGTON</i>	ADDRESS	25a. REC'D BY REGISTRAR DATE <i>OCT 11 1967</i>	25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11903

CERTIFICATE OF DEATH

11922

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 02/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 441 4th Street	
3. NAME OF DECEASED (Type or print) Baby First Middle Last TEAT		4. DATE OF DEATH Month Day Year September 24 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 24, 1967
9. AGE (In years lost birthday) yrs. 9		10. IF UNDER 1 YEAR Months Days Hours Min. 24 19 67	
11. DO USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)		12. CT. ZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Ronald Jacob		14. MOTHER'S MAIDEN NAME Evelyn Teat	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Clayton Teat 441 4th St		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 116X DUE TO Chromosomal abnormality Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Chromosomal abnormality DUE TO Chromosomal abnormality (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)	
21. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	22. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	24. (City or town) (County) (State)
25. I certify that (I) (this hospital) attended the deceased from 9-24-67 , to 9-24-67 , that (I) (we) last saw the deceased alive on 9-24-67 , and that death occurred at 9:15 P.M. from causes and on the date stated above.			
26. SIGNATURE A. T. Allen		27. DATE SIGNED 9-25-67	
28. PHYSICIAN'S NAME (Type) A. T. ALLEN		29. ADDRESS 62 Calver St.	
30. BURIAL CREMATION, REMOVAL (Specify)	31. DATE THEREOF 9-29-1967	32. NAME OF CEMETERY OR CREMATORY Pine Lawn	33. LOCATION (City or Town) (County) (State) Annapolis Md.
34. FUNERAL DIRECTOR William Reese #1		35. REC'D BY REGISTRAR Charles Judge	
36. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 2 1967	

11909

CERTIFICATE OF DEATH

11923

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL (Anne Arundel) MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE MARYLAND Anne Arundel BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT GEORGE G, PLEADE, MD.		c. LENGTH OF STAY IN TB 2 HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d. STREET ADDRESS 5341 WASENA AVENUE 21225	
3. NAME OF DECEASED (Type or print) F. S. T. M. D. L. Y. WALTER D. DEMICKI TELECK		4. DATE OF DEATH Month Day Year SEPT 4 1967	
5. SEX MALE	6. COLOR OR RACE CAUC	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1897 30 SEPT 1898
9. AGE (in years) 69 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET MSGT		10b. KIND OF BUSINESS OR INDUSTRY ARMY	
11. BIRTHPLACE (County & State, or foreign country) MAYFIELD, PA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DEMITRI TELECK		14. MOTHER'S MAIDEN NAME EVA EWUACA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES 1917-1919		16. SOCIAL SECURITY NO 1917-1919	
17. INFORMANT SAMUEL POLEN		Address 7 ALBERT MERTYLE. ROCKVILL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 5 HRS.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4 SEPT , 19 67 , to _____, 19____, that (I) (we) last saw the deceased alive on 4 SEPT 19 67 , and that death occurred at 345P M, from causes and on the date stated above.			
22a. SIGNATURE Carl Rosen		22b. DATE SIGNED 4 Sept 67	
22c. PHYSICIAN'S NAME (Type) CARL ROSEN, CPT, MC		22d. ADDRESS	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 9/8/67	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Fort Meyer, Virginia
24. FUNERAL DIRECTOR Mc Cully Funeral Home		25a. REC'D BY REGISTRAR SEP 8 1967	
25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11950

11924

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on, Res dence before admision) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN IS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel General Hospital		d. STREET ADDRESS 630 Americana Drive	
3. NAME OF DECEASED (Type or print) Elizabeth TERRY		4. DATE OF DEATH September 25 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1897
9. AGE (In years last birthday) 70 yrs		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME CLARA E. DONNER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pump failure due to rupture of DUE TO 4201 (b) myocardium due to acute anterior DUE TO myocardial infarction (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH 15 min 36 HRS	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-1 , 19 67 to 9-25 , 19 67 , that (I) (we) last saw the deceased alive on 9-25 , 19 67 , and that death occurred at 12:40 P.M. M, from causes and on the date stated above			
22a. SIGNATURE Peter F. Verkouw		22b. DATE SIGNED 9-26-67	
22c. PHYSICIAN'S NAME (Type) Peter F. Verkouw M. D.		22d. ADDRESS 1407 Forest Drive, Annapolis, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) 9-26-67	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State) BUFFALO NY
24. FUNERAL DIRECTOR JOHN M. TAYLOR, SOBS ANNAPOLIS MD		25a. REC'D BY REGISTRAR OCT 2 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Jones			

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11911

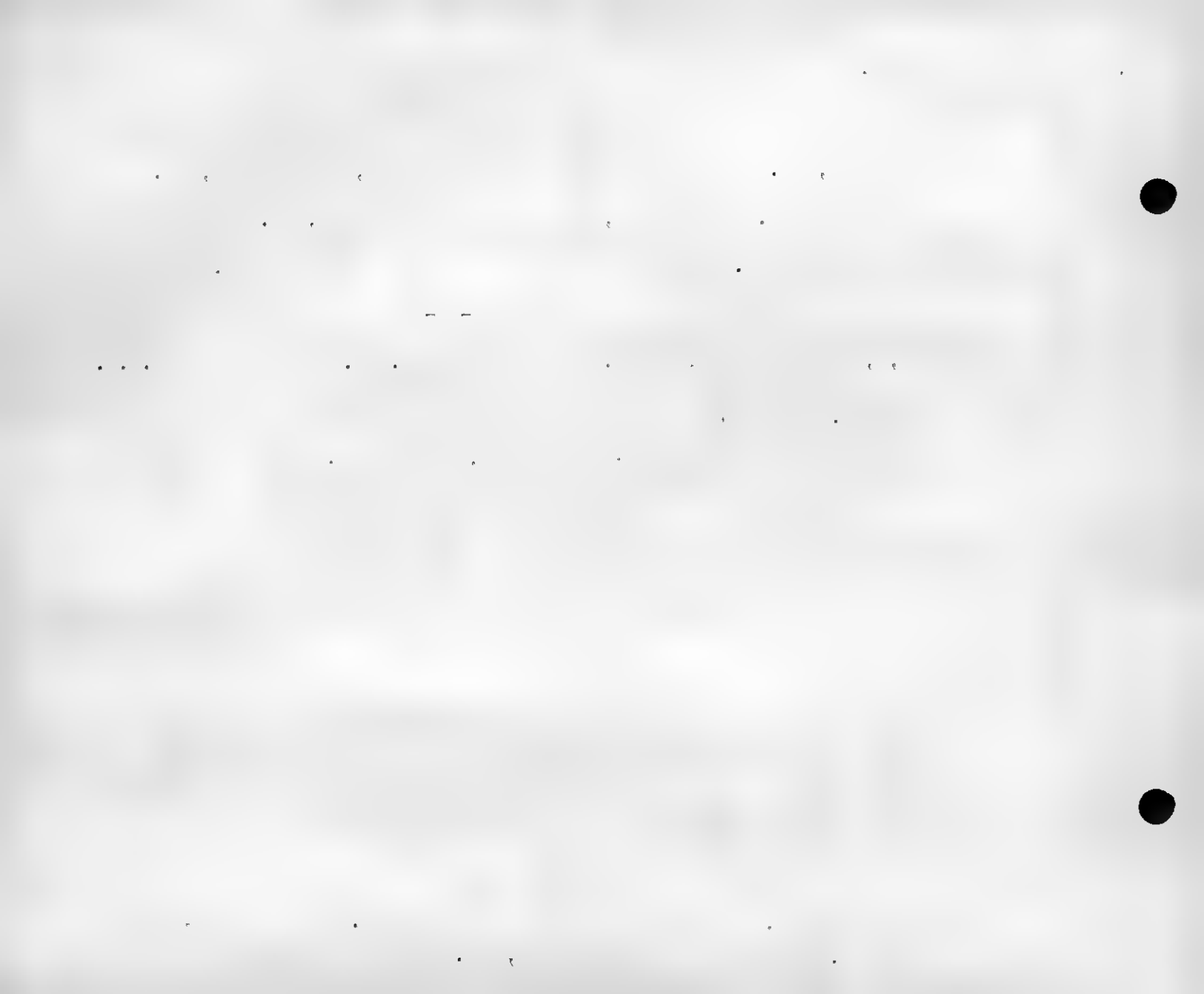
CERTIFICATE OF DEATH

11925

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Md.		c. LENGTH OF STAY IN lb 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale, Glen Burnie, Md.		d. STREET ADDRESS 12 Second Ave, So.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hosp. Glen Burnie, Md		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James C. Middle Thompson Last 4. DATE OF DEATH Month Sept. Day 14 Year 19 67			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-87
9. AGE (In years last birthday) yrs 79		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Arrow Brewery, Balto.		10b. KIND OF BUSINESS OR INDUSTRY Balto. Md.	
11. BIRTHPLACE (County & State, or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James W. Thompson		14. MOTHER'S MAIDEN NAME Emma Weber	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-01-9289-A	
17. INFORMANT Mrs. Dorothy E. Adams (Friend) # 2		Address Same as	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septic shock 609X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) For my 3rd time Septic DUE TO (c) Many short life		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 67 , to 7-13 , 19 67 , that (I) (we) last saw the deceased alive on 7-3 , 19 67 , and that death occurred at 9:30 M, from causes and on the date stated above.			
22a. SIGNATURE Wayne B. Tate		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WAYNE B. TATE		22d. ADDRESS 108 Central Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Pk.		23d. LOCATION (City or Town) (County) (State) Glen Burnie, Maryland	
24. FUNERAL DIRECTOR Richard V. Singleton		25a. REC'D BY REGISTRAR Glen Burnie, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE SEP 18 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH 77926

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA Anne Arundel General Hospital</u>				d. STREET ADDRESS <u>21 N. Glen Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>ANDERSON</u> Last <u>TONGUE, SR.</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>13</u> Year <u>1967</u>		5. SEX <u>male</u>		6. COLOR OR RACE <u>caus.</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 27, 1919</u>		9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>power station operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>public utilities</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Tongue</u>				14. MOTHER'S MAIDEN NAME <u>Addie Robertson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>214-05-1337</u>		17. INFORMANT <u>Mrs. Thelma H. Tongue - same as #2 above</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4301 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral Heart Disease</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>2 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>66</u> , to <u>13 Sept</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>13 Sept</u> , 19 <u>67</u> , and that death occurred at <u>5:4</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward S. Beck</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Edward S. Beck, MD</u>	
22d. ADDRESS <u>Franklin St., Annapolis, Md.</u>				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 16, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Annapolis, Anne Arundel, Md.</u>	
24. FUNERAL DIRECTOR <u>Beverly E. Hopping</u> <u>HO PING FUNERAL HOME - Annapolis, Md.</u>				25a. REC'D BY REGISTRAR <u>SEP 18 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. ADDRESS			

CERTIFICATE OF DEATH

11927

11916

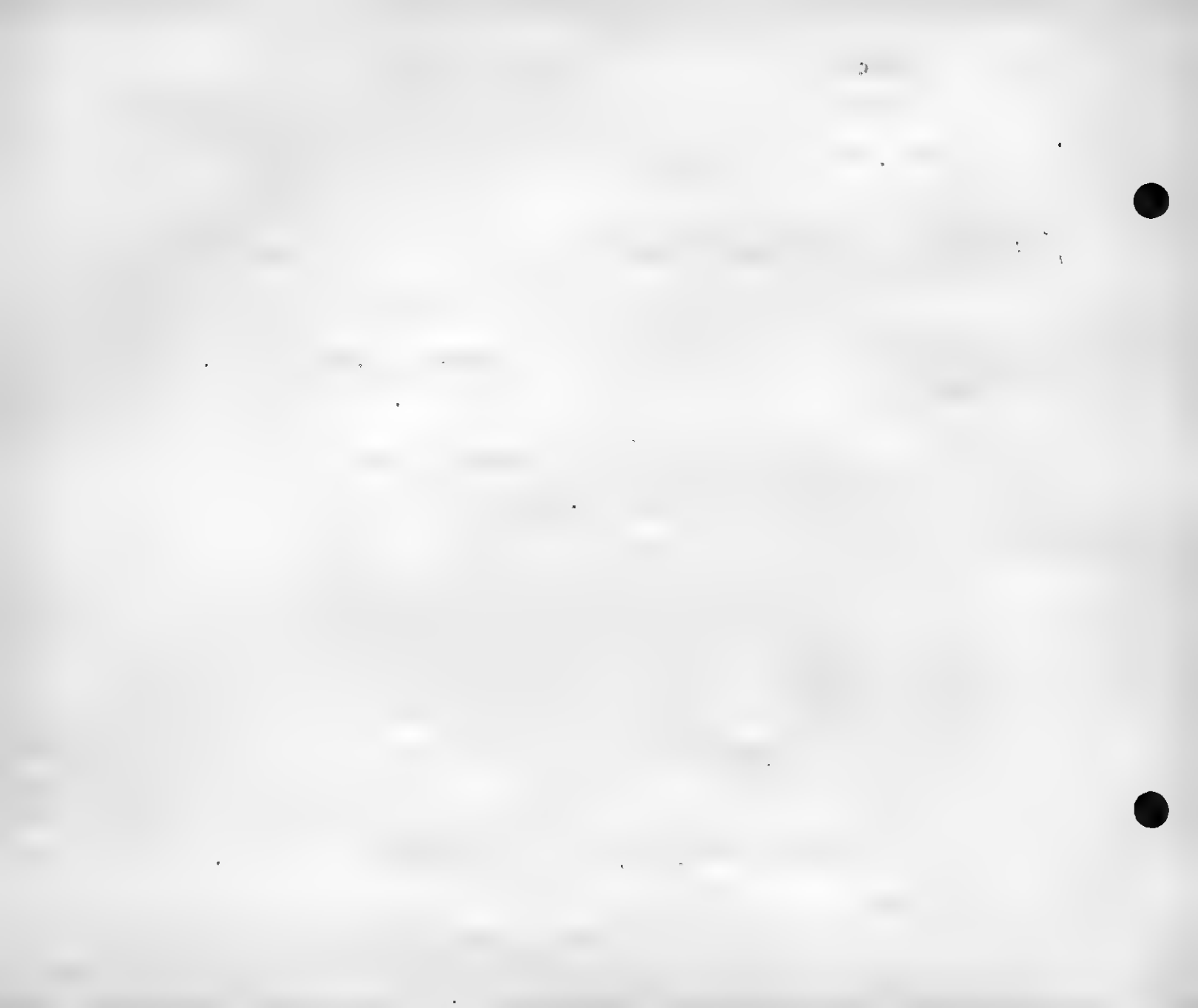
1 PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE MARYLAND b. COUNTY PRINCE GEORGE	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FT GEO G. MEADE, MARYLAND		c LENGTH OF STAY IN IT 15 Min	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KIMBROUGH ARMY HOSPITAL		d STREET ADDRESS 13913 BRIARWOOD DRIVE	
3 NAME OF DECEASED (Type or print) MARGARET MILDRED VAIL (Veal) First Middle Last		4. DATE OF DEATH SEPTEMBER 15 19 67 Month Day Year	
5 SEX F	6 COLOR OR RACE CAU	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5 SEPTEMBER 84 18 81 Month Day Year
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b KIND OF BUSINESS OR INDUSTRY NONE	
11 BIRTHPLACE (County & State or foreign country) LACKAWANNA, SCRANTON, PA.		12 CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME MICHAEL SHEA		14 MOTHER'S MAIDEN NAME MARY A. CORBETT	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No) N/A (If yes give year or dates of service)		16 SOCIAL SECURITY NO. 200-36-6652	
17 INFORMANT CHARLES VAIL(S) Same as 2-D Address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SHOCK, ETIO. UNKNOWN DUE TO (b) UNKNOWN DUE TO (c) UNKNOWN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) Charles Judge attended the deceased from 0940 hrs 15 Sept 67 , 19 67 , that (I) Charles Judge saw the deceased alive on 15 Sept 1967 , and that death occurred at 0955 AM , from causes and on the date stated above.			
22a SIGNATURE Lynn W. Holder		22b DATE SIGNED 15 September 67	
22c PHYSICIAN'S NAME (Type) LYNN W. HOLDER, CPT, MC		22d ADDRESS KIMBROUGH AH FT GEO G. MEADE, MARYLAND	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF SEPT 18, 1967	23c NAME OF CEMETERY OR CREMATORY Cathedral Cemetery	23d LOCATION (City or Town) (County) (State) Scranton Lacka Penna
24 FUNERAL DIRECTOR Funeral Home - Laurel, MD.		25a REC'D BY REGISTRAR SEP 18 1967	25b REGISTRAR'S SIGNATURE Charles Judge

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health or to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11914

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11928

1 PLACE OF DEATH a COUNTY <u>H.A. Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>MARYLAND</u> b COUNTY <u>H.A.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u>		c LENGTH OF STAY IN 1b <u>EDGEWATER</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MIDLAND RD.</u>		d STREET ADDRESS <u>MIDLAND RD.</u>	
3 NAME OF DECEASED (Type or print) First <u>MILAS</u> Middle <u>RICHARD</u> Last <u>WALLACE</u>		4 DATE OF DEATH Month <u>9</u> Day <u>25</u> Year <u>1967</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>8-16-1925</u> 42 yrs
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FLOOR SANDER Construction</u>		10b KIND OF BUSINESS OR INDUSTRY <u>W. W.</u>	
11 BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>RICHARD D. WALLACE</u>		14 MOTHER'S MAIDEN NAME <u>ONIE DAYLEY</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <u>yes WW II</u>		16 SOCIAL SECURITY NO <u>ONIE D. WALLACE #2</u>	
17 INFORMANT <u>ONIE D. WALLACE</u>		Address <u>#2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4500</u> DUE TO <u>Arteriosclerosis, generalized</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO _____ (c) _____			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4500</u>			
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u> MO		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. [Signature]</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>9-26-67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>9-28-67</u>	<u>GLEN HAVEN</u>	<u>GLEN BURNIE MD.</u>
24 FUNERAL DIRECTOR	ADDRESS		25a REC'D BY REGISTRAR
<u>John M. [Signature]</u>	<u>Annapolis, Md.</u>		<u>OCT 2 1967</u>
			25b REGISTRAR'S SIGNATURE <u>[Signature]</u>



11915

CERTIFICATE OF DEATH

77929

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Delaware</u> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c LENGTH OF STAY IN b <u>Delmar</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Crownsville State Hospital</u>		d STREET ADDRESS <u>Delmar</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Rudolph Walters</u>		4. DATE OF DEATH Month Day Year <u>9 18 1967</u>	
5 SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/86</u>
9 AGE (In years lost birthday) <u>81</u> yrs		IF UNDER 1 YEAR Months Days Hours Min <u>18 19 67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unemployed</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jeff Walters</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO <u>unknown</u>	
17. INFORMANT <u>Hospital Records, Crownsville, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome due to Cerebral arteriosclerosis</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (it) (this hospital) attended the deceased from <u>5/78</u> , 19 <u>67</u> , to <u>9/78</u> , 19 <u>67</u> , that (it) (we) last saw the deceased alive on <u>9/78</u> , 19 <u>67</u> , and that death occurred at <u>11:40</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Benedict</u>		22b. DATE SIGNED <u>9/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Benedict, M.D.</u>		22d. ADDRESS <u>Crownsville State Hospital, Maryland</u>	
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>REMOVAL</u>		23b. DATE THEREOF <u>10.5.67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chesapeake Med. School</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm Reese Jr 108 W. Washington St</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 6 - 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

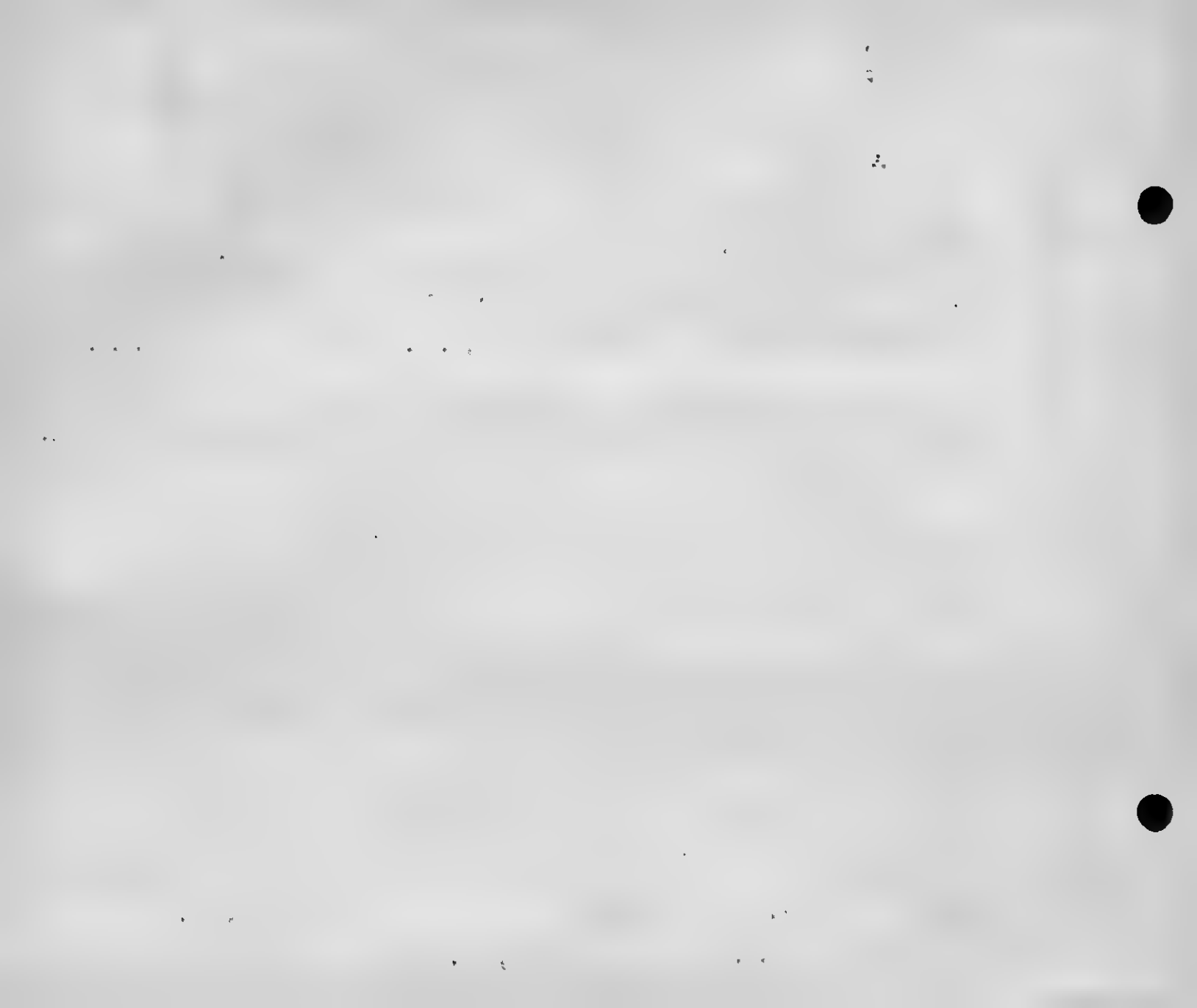
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15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11915 CERTIFICATE OF DEATH 11930									
1. PLACE OF DEATH a. COUNTY AA Co MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY AA Co				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7926 East End Dr					d. STREET ADDRESS 7926 East End Dr				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Katherine E Watkins			First Middle Last		4. DATE OF DEATH Sept 28 1967		Month Day Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 21 1887		9. AGE (In years last birthday) 80 yrs.		10. FUNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Baker					14. MOTHER'S MAIDEN NAME Frances				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Family			Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Cardiac decompensation DUE TO (b) Arteriosclerotic cardiovascular disease DUE TO (c) disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH 10 days 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 15, 1944, to September 28, 1967, that (I) (we) last saw the deceased alive on Sept. 21 1967, and that death occurred at 6:15 M, from the causes and on the date stated above.									
22a. SIGNATURE R.M. McLaughlin					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/28/67
22c. PHYSICIAN'S NAME (Type) R.M. McLaughlin					22d. ADDRESS 3718 Mountain Rd. Pasadena, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9/30/67		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		23d. LOCATION (City, town or county) (State) AA CO Md		
24. FUNERAL DIRECTOR Mc Cully F.H. V37					ADDRESS Folapso ave		25a. REC'D BY REGISTRAR SEP 29 1967		25b. REGISTRAR'S SIGNATURE Charles J...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11917 Item 2 Filed 11/13/67											
CERTIFICATE OF DEATH											
11931											
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glen Burnie Annapolis					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Plaza Manor Nursing Home						e. STREET ADDRESS College Creek Terrace					
3. NAME OF DECEASED (Type or print) First Arthur Middle WM Last Wells						4. DATE OF DEATH Month Sept ; Day 16 Year 1967					
5. SEX Male		6. COLOR OR RACE Neuro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOW <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 13-1877		9. AGE (In years last birthday) 90 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction laborer		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) A.A.Co. Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Nelson Wells						14. MOTHER'S MAIDEN NAME Patricia Butler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No						16. SOCIAL SECURITY NO. None		17. INFORMANT Address Samuel Wells - 64 College Crk Terrace Anna. Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion											
Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardiovascular Disease											
causing the underlying cause last (c) Senility											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from 7-21-1967 to 9-16-1967 , that (I) (we) last saw the deceased alive on 9-16-1967 , and that death occurred at 5 AM , from the causes end on the date stated above.											
22a. SIGNATURE Richard H. Hunt						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Richard H. Hunt		22d. ADDRESS 100 Chesapeake Ave. Baltimore, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 19-67		23c. NAME OF CEMETERY OR CREMATORY Brewer Hill		23d. LOCATION (City, town or county) Annapolis, Md. (State) _____					
24. FUNERAL DIRECTOR'S SIGNATURE Charles E. Hicks						ADDRESS C.E. Hicks 111 Annapolis, Md.		25a. REC'D BY REGISTRAR DATE SEP 22 1967		25b. REGISTRAR'S SIGNATURE	



11918

CERTIFICATE OF DEATH

11932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

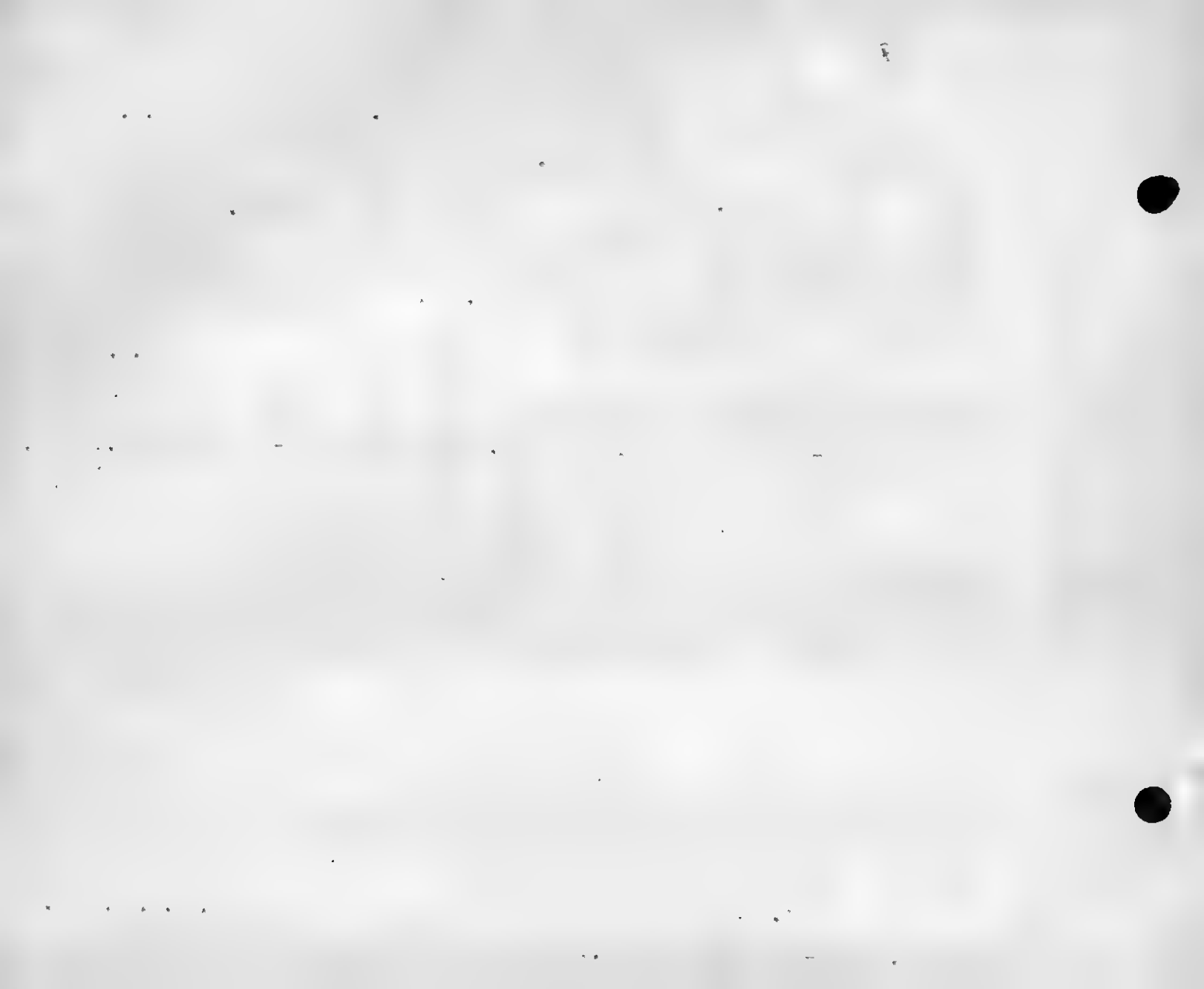
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Anne Arundell</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Baltimore</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Spring</u>		c LENGTH OF STAY IN 1b		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>North Annapolis Convalescent Center</u>				d STREET ADDRESS <u>1500 Boyd St 21230</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Gertrude Marie Wetters</u>				4 DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1967</u>			
5 SEX <u>F</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/20/1896</u>		9 AGE (In years <u>71</u> yrs birthday)	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State or foreign country) <u>Baltimore Md.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Charles Sudbrook</u>				14 MOTHER'S MAIDEN NAME <u>Rosezella Adams</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO.		17 INFORMANT <u>Mr Harry V. Wetters</u> Address <u>1653 Longford Rd 21207</u>			
18 CAUSE OF DEATH (Enter only one cause per me far (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CVA</u> 331X DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>ASHD</u>							19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOT BY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>10</u> p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>August 5, 1967</u> , to <u>Sept 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>Sept 2, 1967</u> , and that death occurred at <u>11:15</u> M, from causes and on the date stated above							
22a SIGNATURE <u>J. B. Ramirez MD</u>				22b DATE SIGNED <u>9/4/67</u>		22c PHYSICIAN'S NAME (Type) <u>J. B. RAMIREZ MD</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>9/6/67</u>		23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d LOCATION (City or Town) (County) (State) <u>A.A. Co. Md.</u>	
24 FUNERAL DIRECTOR <u>McCully Funeral Home</u>				25a REC'D BY REGISTRAR DATE <u>SEP 5 1967</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
11918									
11922									
1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena c. LENGTH OF STAY IN 1b 15 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 245A Poplar Ridge Rd.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY A.A. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pasadena d. STREET ADDRESS 245A Poplar Ridge Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First VERNON Middle EDWARD Last WHITE					4. DATE OF DEATH Month September Day 8 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 11, 1904		9. AGE (In years last birthday) 63 IF UNDER 1 YEAR: Months 6 Days 1 Hours 1 Min. 1 IF UNDER 24 HRS: Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				10b. KIND OF BUSINESS OR INDUSTRY Davison Chemical		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Albert White					14. MOTHER'S MAIDEN NAME Emma Travers				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) 1942-1945				16. SOCIAL SECURITY NO. 215-24-7857		17. INFORMANT Mrs. Charles Anderson-191 Meadow Rd., Balto. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4301 Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerotic heart disease (c) essential hypertension in									INTERVAL BETWEEN ONSET AND DEATH 24 hours 6 months 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (the hospital) attended the deceased from July 10, 19 65 to Sept. 8, 19 67 , that (I) (we) last saw the deceased alive on Sept. 6, 19 67 , and that death occurred at 1 A.M. from the causes and on the date stated above.									
22a. SIGNATURE R.M. McLaughlin					22b. DATE SIGNED 9/8/67		22c. PHYSICIAN'S NAME (Type) R.M. McLaughlin, M.D.		
22d. ADDRESS 3708 Mountain Rd. Pasadena Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Sept. 11, 1967		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Ritchie Hgwy., A.A. Co., Md.		
24. FUNERAL DIRECTOR George J. Gonce-4001 Ritchie Hgwy., Baltimore					25a. REC'D BY REGISTRAR SEP 13 1967 25b. REGISTRAR'S SIGNATURE J. J. Jones				



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

11920

CERTIFICATE OF DEATH

11934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY in lb <u>00A</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>M Arundel Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>M</u> <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> d. STREET ADDRESS <u>Box 188 Rt. #1 Elvaton Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY ELLEN WOOD</u> First Middle Last		4. DATE OF DEATH <u>Sept. 10 1967</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 25, 1879</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Anne Arundel Co. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Richard Martin</u> 14. MOTHER'S MAIDEN NAME <u>Mary Anne Dallas Gaither</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>219-54-3243-J1</u> 17. INFORMANT (daughter) <u>Mrs. Buelah Manthe</u> Address <u>Box 278 Elvaton Road Millersville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic heart disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>			
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>		21. I certify that (I) (the informant) attended the deceased from <u>Mar. 1951</u> to <u>Aug. 9 1967</u> that (I) (we) last saw the deceased alive on <u>Aug. 9 1967</u> , and that death occurred at <u>11A</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Samuel Rubin</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>9/11/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Samuel Rubin, M.D.</u>		22d. ADDRESS <u>203 E. Patapsco Avenue Baltimore, Md. 21225</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 13, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wood's Family Cemetery</u>			
23d. LOCATION (City, town or county) <u>Millersville Maryland</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Eugene B. Flannery</u> ADDRESS <u>Singleton Funeral Home Glen Burnie, Md.</u>					
25a. REC'D BY REGISTRAR <u>SEP 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS 4-4. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11935

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. A.A. General Hosp.</u>				d. STREET ADDRESS <u>1968 West St.</u>		02.1	
3. NAME OF DECEASED (Type or print) <u>Florine C. Wright</u>				4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-19-1925</u> 41 yrs.	
9. AGE (In years last birthday)				10. IF UNDER 1 YEAR Months <u>4</u> Days <u>1</u>		11. IF UNDER 24 HRS Hours <u>1</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dish Washer Feed Drugs</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Wright</u>				14. MOTHER'S MAIDEN NAME <u>Annie Wright</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-18-5054</u>		17. INFORMANT <u>Jane Simms - Annapolis Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4344 IMMEDIATE CAUSE (a) <u>Acute dilatation of the heart</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Albert H. Anderson</u> M.D.				22. DATE SIGNED <u>44 Some yds 9/3/67</u>			
EXAMINER'S NAME (Type) <u>ALBERT H. ANDERSON</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>9/7/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn</u>		23d. LOCATION (City or town) (County) (State) <u>Best Gate A.A. Md</u>	
24. FUNERAL DIRECTOR <u>William Reese, II - Anna. Md.</u>				25a. REC'D BY REGISTRAR DATE <u>SEP 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

The following is a list of the names of the persons who have been
 named in the report of the committee on the subject of the
 proposed amendment to the constitution of the State of New York.
 The names are given in alphabetical order, and are those of the
 persons who have been named in the report of the committee on the
 subject of the proposed amendment to the constitution of the State of
 New York.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11922

11936

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Pro George's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. LENGTH OF STAY IN 1b /////		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edmonston, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Arundel Hospital				d. STREET ADDRESS 5200 47th avenue			
3. NAME OF DECEASED (Type or print) WALTER S. YOUNG				4. DATE OF DEATH September 9, 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1896	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Navy Yard		10b. KIND OF BUSINESS OR INDUSTRY U S Government		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME James Young				14. MOTHER'S MAIDEN NAME Katherine Ferguson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W W I		16. SOCIAL SECURITY NO. 217 52 6020		17. INFORMANT Viola M Johnson Address Ananover, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma, Right Lung DUE TO (b) 163X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Richard I. Hochman, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 16 Murray Ave Annapolis, Md 9/9/67	
EXAMINER'S NAME (Type) Richard I. Hochman, MD		22. DATE SIGNED 9/9/67		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 13, 1967		23c. NAME OF CEMETERY OR REPOSITORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia.	
24. FUNERAL DIRECTOR F. Gasch's Sons ADDRESS Hyattsville, Md.				25a. REC'D BY REGISTRAR DATE SEP 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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James M. ...

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James M. ...

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